

PERSONALITY ADJUSTMENT AND ANXIETY
OF NURSING AIDES IN NURSING HOMES

By

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To my Mother and Father
whose love and concern for others
motivated their lives

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Abstract of Dissertation Presented to the Graduate School
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The purpose of this study was to investigate personality adjustment and anxiety of nursing aides currently employed in nursing homes and to relate these factors to various demographic and work-related variables. Personality adjustment was determined by scores on the Rotter Incomplete Sentences Blank (RISB); anxiety was measured by scores on the Trait-Anxiety scale (Form Y-2) of the State-Trait Anxiety Inventory (STAI, Form Y).

Volunteer participants in the study were 124 nursing aides from five nursing homes. Research data were analyzed using multiple regression, t-tests for sample means, Pearson product moment coefficients of correlation, and frequency distributions.

By criteria established for the RISB, 20% of the aides in the study had personality adjustment scores indicating strong conflict in interpersonal relationships. The mean

anxiety score was significantly higher for nursing aides than the norm established by the STAI for working adults. A positive correlation existed between personality adjustment scores and anxiety scores.

Using a linear regression model, neither personality scores nor anxiety scores were significantly related to age, length of time employed in nursing homes, or the number of homes in which aides had worked. In a separate analysis using a linear model, personality adjustment scores and anxiety scores were regressed on nursing home, work shift, liking of job, and gender. For personality adjustment scores, whether an aide liked or disliked the job was the only significant variable; for anxiety scores, the significant variables were nursing home, shift, and age.

CHAPTER I INTRODUCTION

The aging of the adult population in the United States has had a significant effect on the growth rate in the number of patients in nursing homes. Data from national health surveys conducted by the U.S. Department of Health and Human Services indicated there were 75% more patients in nursing and related care homes with 25 or more beds in 1980 than in 1969 (Strahan, 1984). The 1985 National Nursing Home Survey showed 1.5 million residents in nursing homes, representing a 39% increase in their number since the 1973-74 survey (Strahan, 1987).

Persons age 85 and older accounted for 76% of the increase in elderly nursing home residents from 1977 to 1985 (Hing, 1987). Approximately one in ten persons 75 or older and one in five persons 85 or older currently live in a nursing home (Committee on Nursing Home Regulation, 1986). If the trend of institutionalization patterns continues, the Health Care Financing Administration has projected that the number of nursing home residents will increase 54% from 1981 to 1991 and 132% by the year 2030 (U.S. Department of Health and Human Services, 1981).

Although the number of persons being cared for in nursing homes is steadily increasing, public attitudes are predominately negative toward institutional care (Krause, 1982).

In the minds of many Americans, a nursing home conjures up mental pictures of sickness, of people sitting around staring at invisible images, of groans, of smells, of loneliness and death (p. 19). . . . The attitudes of Americans toward old age institutions vary from a calm disapproval to an emotional condemnation, from a mild reluctance to an almost paralyzing fear. Their feelings may differ in degree, but only in degree; Americans do not like old age institutions. (p. 24)

According to Vladeck (1980, p. 29), the typical nursing home is a "pretty awful place" because the medical and social circumstances of the people living there are extremely difficult to change and because there is an inadequate supply of individuals motivated, educated, and trained to work effectively in that environment.

The quality of life for the ever-increasing number of persons residing in nursing homes and the physical care and emotional comfort many of them receive in their dying will depend, in large measure, on the personal attributes of the nursing staff who will care for them. Linn, Gurel, and Linn (1977) studied 1,000 male patients transferred from a general medical hospital into 40 nursing homes to determine factors contributing to the patient's improvement, no change, deterioration, or death. The researchers concluded that once minimum standards of care are met, "it is other

factors, such as a kind of atmosphere of the home or personalities of the staff, that influence patient outcome" (p. 342).

Mullan (1961) stressed the importance of the caregiver's personality in working with older persons.

It is the dynamic organization of personality traits which determines how one adjusts to, relates to, and participates with the aging person (p. 43). . . . In geriatric care, second only to the aging person himself, the personality of the one charged with his care is important. Selection of personnel, particularly those in the day-to-day contact with the elderly becomes crucial. (p. 49)

Nursing Aides

The nursing aide has, by far, the most extensive personal interaction with the patient of any staff member in the nursing home. Aides comprise 43% of the total number of nursing home employees and 71% of the nursing staff (Strahan, 1987; National Institute on Aging, 1987). Aides are responsible for 90% of the direct patient care (LeSar, 1987; Waxman, Carner, & Berkenstock, 1984). According to Vladeck (1980),

It is aides who rouse the patients in the mornings, escort them to the bathroom and to meals, assist them in dressing, clean up after them, and as a general rule administer--illegally--at least some of their medication. When residents cannot walk, aides lift them out of bed and push their wheelchairs. When residents are incontinent, aides clean up after them. When residents cannot bathe themselves, aides assist them. When residents cannot speak or make themselves understood, aides must divine their meaning. Few jobs in this society are worse than those of aides in nursing homes. (p. 20)

Fox (1982) noted that the aide "wields a powerful weapon-- the power of kindness over abuse, hope over despair, dignity over degradation, joy over gloom. The aide brandishes a sword that can strike life or death to the human spirit" (p. 68).

According to the Occupational Outlook Handbook, 1988-89 edition, published by the U.S. Department of Labor (1988),

Hiring requirements for nursing and psychiatric aides are usually minimal; neither a high school diploma nor previous work experience is necessary in many cases. Limited education and rudimentary English language skills do not ordinarily stand in the way of getting a job. Personal qualifications such as dependability, integrity, and a pleasant manner are the principal requirements. (p. 273)

Further, it is noted in the handbook that, because of the increasing number of aging persons in the population of the U.S. and the increase in their long-term health care needs, nursing aide employment is expected to grow faster than the average for all occupations.

The writers of Supporting Paper No. 4 of the U.S. Senate's Subcommittee on Long-Term Care (Special Committee on Aging, 1975) called the work "very hard, undesirable, and unpleasant" (p. 371). The Committee on Nursing Home Regulation of the Institute of Medicine (1986) noted that care in nursing homes is expensive because it is staff-intensive and added,

To hold down costs, most of the care is provided by nurse's aides who, in many nursing homes are paid very little, receive relatively little training, are inadequately supervised, and are required to care for more residents than they can serve properly. Not surprisingly, the turnover rate of nurse's aides is usually very high--from 70% to over 100% per year--a factor that causes stress in resident-staff interactions. (p. 11)

Approximately 25% of all aide positions are vacant at any one time (U.S. Department of Health and Human Services, 1981). Nursing homes are required by government regulatory agencies to maintain stipulated aide/patient ratios. High rates of turnover resulting in constant vacancies create serious problems for management to maintain these ratios. Researchers agree that age is a strong correlate of turnover; the younger the aide, the more likely the aide will be to leave. Another strong correlate is length of current employment; the longer the aide has been employed in a facility, the greater the probability the aide will remain (George, 1979; Halbur, 1982; Molberg, 1978; Rublee, 1986; Wallace & Brubaker, 1984).

Information is inadequate concerning job migration of nursing aides from one nursing home to another. It has been hypothesized that many aides who leave one facility will eventually return to work in the same or another nursing home (Halbur, 1982; Kasteler, Ford, White, & Carruth, 1979; Vladeck, 1980). In a consensus opinion, 175 nursing home administrators, directors of nursing, and other supervisory staff estimated that 70% to 80% of

nursing aides who leave voluntarily or are fired from one nursing home go to work in another nursing home (Cunningham & Parsons, 1987). Therefore, it is postulated that most nursing homes are caught in a cycle of hiring aides, the majority of whom will not stay long, and are forced to return to much the same pool of applicants to hire replacement aides.

Statement of the Problem

On a daily basis there are more patients in nursing homes than in acute care hospitals (National Institute on Aging, 1987). The lifetime risk of spending time in a nursing home may exceed 50% (McConnel, 1984).

In the nursing home environment the interpersonal relationship of patient and caregiver--especially the patient/aide relationship--is critical to the patient's quality of life (Bagshaw & Adams, 1985-86; Committee on Nursing Home Regulation, 1986; Stein, Linn, & Stein, 1986). In a study related to patient abuse, Pillemer and Moore (1989) surveyed 577 nurses and aides in 57 nursing homes. Thirty-six percent of the respondents reported seeing at least one incidence of physical abuse of patients in the past year; 81% reported observing at least one incidence of psychological abuse in the past year. Of the respondents, 10% admitted having themselves physically abused a patient; 40% admitted having psychologically abused a patient.

The low education and training requisites for aide employment, combined with the constant need by most nursing homes to fill vacancies, make being hired as an aide likely for most applicants. As a result, nursing homes may be hiring many aides whose personality adjustment and level of anxiety make them unsuited to caring for nursing home patients who are so vulnerable to both physical and verbal abuse. In addition, the personality of one nursing aide affects the work environment and work-related anxiety experienced by other staff.

Although it has been recognized that an assessment of personality functioning of staff could be vitally important to nursing homes (Boling, Vrooman, & Sommers, 1983) and that job-related anxiety in nursing homes needs study (Pennington & Pierce, 1985; Wright, 1988), little research has been conducted in these areas. Neither have researchers examined the relationship between an aide's personality adjustment and anxiety level and related these factors to demographic and work-related variables.

Theoretical Framework of Study

Warmth, dependability, caring, and a positive attitude--each a facet of a well-adjusted personality--are more important requisites for being a nursing aide than are educational requirements (Kramer & Kramer, 1976; U.S. Department of Labor, 1988; Stryker, 1981). Thus, the theoretical framework for this study is derived from a

combined perspective on theories related to personality adjustment and anxiety and to organizational characteristics of the work-place environment which impact personality adjustment and anxiety in interpersonal relationships.

Personality Adjustment

Study of the healthy or well-adjusted personality was largely ignored until humanistic psychologists began to depart from the Freudian psychoanalytic concentration on neurotic and psychotic behavior and to move toward a study of the human potential for growth (Schultz, 1977).

According to Schultz, Gordon Allport was one of the first personality theorists to place emphasis on the healthy personality and to discuss criteria by which it can be measured. Allport (1961) believed the healthy personality has a capacity for intimacy and for compassion which extends beyond family and friends.

Victor Frankl (1973) supported this premise in his logotherapy and stressed that healthy personalities have a commitment to their work and to other persons which transcends self and gives meaning to life. He believed that courage in the face of suffering and death is the ultimate challenge for finding meaning to life. This concept directly addresses the relationship of personality to a commitment to work in an institution where suffering

and death are inextricably interwoven in its everyday existence.

According to Hall and Lindzey (1957), the social dimensions of personality may be measured by the effectiveness of an individual's social skills in interaction with a variety of persons under different circumstances and by the impression which a person creates in others. Tallent (1978) incorporated these social dimensions in his concept of personality adjustment: "A person's adjustment then, depends to a great extent on direct relations with other people, family, school, place of work, community, and the larger society that affects the person directly" (p. 11). White (1956) described persons with a "disordered" personality as those "whose lives in some way go astray, so that they find themselves frustrated, unhappy, anxious, baffled in their deepest desires, misfits in their society" (p. 4). Spielberg (1983) also hypothesized that anxiety is one index of personality adjustment.

Theory of Interpersonal Relations

The interpersonal theory of personality developed by Harry Stack Sullivan (1953) addresses the dynamics of anxiety in human relationships and is relevant to a study of personality in an anxiety-inducing work environment. Sullivan theorized that individual personality cannot be isolated from interpersonal relationships. He believed

that individuals learn to perceive self and others as a result of interaction with other people. According to Sullivan, interaction with others gives rise to anxiety, especially when an individual is criticized, ignored, treated as lacking in intelligence, or other demeaning experiences occur.

Because they are the primary source of contact with patients and the public who come as visiting families, aides receive the brunt of criticism about the facility as well as about themselves (Browning, 1983). They also directly and indirectly receive censure from those above them in the organization hierarchy. Fischer (1970) defined the concept of anxiety as an "intermittent, occasionally chronic sense of failure as a human being" (p. 34). Many nursing aides may be particularly vulnerable to anxiety as a chronic sense of failure because of a lack of education and marketable job skills, often combined with a minority status, and exacerbated by the negative public image of nursing homes and the low prestige of the nursing aide position (George, 1979; Halbur, 1982; Stryker, 1981; Vladeck, 1980).

Personality and Organization of Work Setting

Personality and organization theory addresses the complex relationship between persons and work, particularly work in a physically and emotionally taxing environment, such as a nursing home. Argyris (1976) posited that most

organizational management systems approximate a pyramid in shape with centralization of power at the upper levels of management. According to Argyris, the lower the individual is in the chain of command and the more directive the leadership, the more likely low-level employees will be to experience frustration, conflict, short time perspective, and psychological failure. In order for these employees to cope with their work-related anxieties, Argyris hypothesized that they will try (a) fighting the organization to gain more control, such as creating a union; (b) increasing the pay-off from meaningless work; (c) leaving the organization permanently or periodically; or (d) staying in the organization and becoming indifferent and apathetic.

Nursing homes operate on a hierarchial medical/hospital model of management. This places aides at the lowest level of the decision-making process with little control over their own sphere of duties and little influence on institutional decision-making. Empirical evidence shows that aides may attempt to cope with their job-related anxieties and conflicts in all the ways theorized by Argyris--attempting to form a union (Goodfellow, 1979), leaving nursing home work temporarily or permanently, or leaving psychologically and becoming apathetic and indifferent to patients. Browning (1983) attested to the anxiety-inducing position of the aide in

the nursing home, "in reality the position of the aide at the bottom of the organizational hierarchy often subjects them to the direction and capricious demands of everyone (clients, visitors, staff) in the facility" (p. 31).

Contribution of This Study to Theory Advancement

Research related to nursing aides who work in an anxiety-inducing institutional setting adds to the theoretical body of knowledge concerning the relationship between personality adjustment and anxiety in interpersonal relationships as theorized by Sullivan. Spielberger (1983) hypothesized from his study of college students who sought counseling that high levels of anxiety-proneness indicate persons who have adjustment problems. Research concerning the relationship of personality adjustment to anxiety level among nursing aides tests the generalizability of Spielberger's hypothesis to less educated and less advantaged persons.

Humanistic personality theorists posit that the well-adjusted personality finds fulfillment in work and serving others. This research, in part, provides a test of that premise. It addresses the question of whether nursing aides who work in an environment where serving others is the primary function are likely to have a well-adjusted personality due to the nature of their work. If so, does the desire to help others also result in a lower level of work-related anxiety or is anxiety inherent in the role of

an aide in a nursing home regardless of a well-adjusted personality and a personal motivation to help others.

Purpose

The purpose of this research was to expand the limited information available to nursing home administrators and directors of nursing concerning criteria for more effective selection, training, and retention of nursing aides, thereby, improving the quality of patient care and the working environment. To accomplish this purpose, the research focused on the personality adjustment and anxiety level of nursing aides currently employed in nursing homes and related these factors to demographic and work-related variables.

Research Questions

The questions addressed in this research were

1. What is the mean personality adjustment score of nursing aides currently employed in selected nursing homes as measured by the Rotter Incomplete Sentences Blank?
2. What is the mean anxiety score of nursing aides currently employed in selected nursing homes as measured by the Trait-Anxiety scale (Form Y-2) of the State-Trait Anxiety Inventory (Form Y)?
3. Is there a relationship between personality adjustment score and anxiety score among these nursing aides?

4. Are the personality adjustment scores of these nursing aides a function of their age, length of time employed in nursing homes, and/or the number of nursing homes in which the aide has worked?

5. Are the personality adjustment scores of these nursing aides a function of the nursing home in which they work, the shift they work, shift-by-nursing home interaction, their age, age-by-shift interaction, whether they like the job, and/or their gender?

6. Are the anxiety scores of these nursing aides a function of their age, length of time employed in nursing homes, and number of nursing homes in which they have worked?

7. Are the anxiety scores of these nursing aides a function of the nursing home in which they work, the shift they work, shift-by-nursing home interaction, their age, age-by-shift interaction, whether they like the job, and/or their gender?

Definition of Terms

Older persons, as designated in this study, are those 65 years of age or older.

A nursing home "is broadly defined as an establishment that provides nursing or personal care to the aged, infirm, or chronically ill" (Strahan, 1984, p. 42).

Nurse's Aides, Nursing Aides, or Nursing Assistants are "people who, under the supervision of a licensed nurse,

provide medical care and assistance with activities of daily living to residents, and who are not themselves licensed to independently provide care" (Committee on Nursing Home Regulation, 1986, p. 399). Male aides who perform the same duties are often called orderlies. Because approximately 93% of the total number of aides are women (Sirrocco, 1981), this study, for ease of reading, uses the term nursing aide to refer to all persons employed under that job description.

Personality adjustment refers to a "state of life when the individual is more or less in harmony with personal, biological, social, and psychological needs and with the demands of the physical environment" (Tallent, 1978, p. 443).

Personality maladjustment is defined in this study as a state of disharmony in personal and interpersonal relationships. It conforms with Tallent's definition of the "troubled personality" as typical of persons who generally have "confused, distorted perceptions of themselves and others. Frequently their interpersonal relationships are marked by severe strain or conflict" (p. 249).

Anxiety is "characterized by subjective feelings of tension, apprehension, nervousness, and worry, and by activation or arousal of the autonomic nervous system" (Spielberger, 1983, p. 1).

A patient, as defined in this research, is a person who receives medical and/or personal care in a nursing home. "Resident" is an interchangeable term. In this study the term "patient" is used because it connotes the more dependent relationship a person suffering from chronic and debilitating disease has with those from whom care is received. In addition, "patient" implies the psychologically vulnerable relationship of the frail older person with the younger, more vigorous staff member. It also symbolizes the medical-model of care under which nursing homes operate.

Practical Significance of the Study

The Subcommittee on Long-Term Care of the U.S. Senate Special Committee on Aging in its 1974 report reached the conclusion that "long-term care for older Americans stands today as the most troubled, and troublesome, component of our entire health care system" (Special Committee on Aging, 1974, p. III). The 1986 report by the same committee indicated little to no improvement since the earlier report. The authors stated, "An alarming number of nursing homes continue to provide grossly inadequate care resulting in humiliation, suffering, and premature death" (Special Committee on Aging, 1986, p. 3).

The National Institute on Aging (1987) reported to Congress that personnel and training needs for nursing home caregivers are among the most critical issues in the health

care of older persons. Changes are needed in orientation and inservice training procedures in nursing homes for more effective staff development (Carter, Kooperman, & Clare, 1988; Helper, 1987; Reagan, 1986). Research which leads to better screening of nursing aides, to improved job skills, and to lower levels of anxiety for aides makes a direct contribution to the quality of care for patients and the nursing home work environment.

A study of the general personality functioning of currently employed aides may provide administrators and supervisory personnel a closer look at those in whom they have invested time and money to hire, provided on-the-job training, and staked much of the public reputation of their facility. A better understanding of the relationship of personality adjustment and anxiety to job stability among aides has the potential to affect the cost of patient care. Nursing homes are labor-intensive organizations which spend an estimated 60% to 70% of their operating revenues for labor costs (Morrow-Winn, 1983; Stryker, 1981). Halbur (1982) estimated that the cost of turnover for nursing homes was over a billion dollars during 1977 and that current costs were even greater.

Organization of the Remainder of the Study

A review of literature relevant to this study is discussed in Chapter II. Chapter III contains a description of the methodology used in the study.

Statistical results of the research are analyzed in Chapter IV. Conclusions drawn from the study, their significance, and areas recommended for further study are presented in Chapter V.

CHAPTER II LITERATURE REVIEW

Major topics covered in this literature review include limitations of the relevant literature, theoretical approaches to the study of personality adjustment/maladjustment and anxiety. Literature related to the general attitudes of society toward the institutionalization of older persons and how these attitudes impact the nursing home environment, and the job of the nursing aide in particular, is also reviewed. Sources of anxiety for aides induced by interpersonal relationships within the nursing home work-place are discussed. These include low staff morale, aide/patient relationships, intra-staff conflicts, emotionally disturbed patients, and the death of patients. Literature related to job satisfaction and job tenure among nursing aides is included in the chapter.

Limitations in Interpreting Relevant Literature

Both the research and the general literature concerning nursing homes are often difficult to locate and to interpret for several reasons: (a) Much of it is subjective; (b) statistical data may have been derived from

sources which are not comparable; and (c) the literature is sparse, generalized, and not easily accessible.

Writers and researchers in the field of aging do not totally escape their own subjective concerns about aging from intruding on their work. In much of the literature on aging emotional words are used which serve to arouse negative feelings and fears. An example is a statement from a document published by the Special Committee on Aging of the U.S. Senate concerning nursing homes and the work of nursing aides: "Few people relish employment calling for cleaning up after the abandoned members of society, many of whom are incontinent" (Special Committee on Aging, 1975, p. 371). Referring to patients as "abandoned members of society" only adds to negative attitudes toward being institutionalized and toward working in that environment, however much it may arouse sympathy for the plight of those living there.

Publications from the U.S. Department of Health and Human Services warn of problems in the use of statistical data regarding nursing homes.

Several factors have contributed to fluctuations in the statistical reporting of nursing homes. One factor is level of care: small homes met the criteria of a nursing home one year and not the next. A second factor is the difficulty in assuring that coverage of small homes is complete because they are most likely to go into (as well as out of) business. A third factor is the use of different data collection mechanisms. (Strahan, 1984, p. 2)

Another notable change in the 1980 inventory is the exclusion of all identifiable hospital-based nursing homes and extended care facilities. . . . From the discussion above, it is apparent that any comparisons between the 1980 and earlier NMFI Surveys must be made with extreme caution. (Sirrocco, 1983, p. 1)

Census and demographic reports concerning nursing homes found in sources other than government documents usually contain data from government surveys and projections. Those statistics may have been derived from data that are not comparable.

Comments by researchers and observers characterize literature related to nursing homes as being generalized, not easily accessible, sparse, and unsystematic. O'Donnell, Collins, and Schuler (1978) found the literature revealed "numerous anecdotal or observational reports but little evidence of systematic study" (p. 267). Stryker (1981) commented that "nursing homes are underresearched, but what research there is, is found in a diverse number of journals and books. This makes access to relevant findings very difficult for the practitioner" (p. 37). A search of the literature at the present time shows Stryker's comments to be still valid.

Comparing studies reported in the literature which include nursing home employees from several departments or even all nursing personnel may not be valid when generalized to nursing aides. These limitations include studies related either to characteristics of persons with

longer job tenure or to factors in the nursing home environment that contribute to staff turnover. As an example, of the total nursing staff, registered nurses (RNs) comprise 12%; licensed practical nurses (LPNs), 17%; and nursing aides, 71% (Strahan, 1987). Between the professional nursing staff composed of RNs and LPNs and the nursing aide staff there are, in general, wide differences in job descriptions, salary, socioeconomic background, educational achievement, age, ethnicity, and turnover rates (Friedsam, 1974; George, 1979, Halbur, 1982, Halbur & Fears, 1986; Strahan, 1988; Winn, Elias, & McComb, 1978).

It is also difficult to compare research data concerning turnover rates because some researchers included personnel who were fired (Kasteler et al., 1979; Petersen, 1979; Stryker, 1981; Waxman et al., 1984); other researchers either did not include them, or the researcher could not ascertain from the available data whether or not those fired were included (George, 1979; Tynan & Witherell, 1984; Wallace & Brubaker, 1984).

A search of the literature indicates an absence of studies relating to the personality adjustment and anxiety level of nursing aides. Practitioners and observers have noted, in general, the anxiety-inducing nature of nursing home work for nursing aides. However, writers on the topic have not placed into perspective the interrelatedness of psychosocial factors both within the nursing home and

outside that environment which may impact personality adjustment and anxiety among aides.

A subjective view of literature related to nursing homes was voiced by a nursing home resident,

The whole problem concerning nursing homes is of paramount interest to our society today, but everything published seems to have been written by an administrator, someone connected with some government agency, or a daughter who may be trying to make herself feel better because she has put her parent in a nursing home. Those of us who are living in nursing homes never seem to be heard from. (Armstrong, 1984, p. 39)

Theoretical Concepts of Personality Adjustment and Anxiety

Sullivan (1953) defined personality as "the relatively enduring pattern of recurrent interpersonal situations which characterize a human life" (p. 111). According to Sullivan, personality cannot be studied apart from an individual's relationships with other persons. Rotter (1954) considered personality a "construct describing the aspect of a unified, complexly organized person that has to do with his characteristic modes of behaving or of interpreting the world in which he lives" (p. 82). Like Sullivan, Rotter believed that the interaction of an individual with that person's meaningful environment is the most appropriate way to study personality. Atchley (1980) posited that although personality is complex and shaped by many different forces making it unique to each individual, the similarity of the biological and social heritage among

large groups of people makes some generalizations about personality possible.

Personality Adjustment/Maladjustment

According to Allport (1961), there are criteria by which the healthy personality can be measured. Among these are the capacity for love and compassion that projects to a sense of kinship with all peoples and an involvement in meaningful activities and interpersonal relationships.

Rogers (1961) considered a healthy personality to be the result of an innate life-long process by which a person works toward developing the unique potentialities of which that individual is capable. Frankl (1962) viewed transcendence of self as the goal in life and the mark of a healthy personality. According to Frankl's theory of logotherapy, the healthy personality is characterized in part by a dedicated commitment to work, an ability to give and receive love, and the capacity to come to terms with suffering and death.

According to Thorpe (1960), if unfavorable pressures are sufficiently numerous and persistent, every mentally healthy person may display symptoms of maladjusted behavior. Personality adjustment/maladjustment is viewed as being positioned along a continuum with no sharp line of demarcation (Patterson, 1958; Thorpe, 1960).

Theoretically, mild forms of maladjustment may cause little social dysfunction while more extreme forms render an

individual unable to function responsibly in interpersonal relationships.

Patterson (1958) posited that persons who are emotionally disturbed are "characterized by internal conflict, which may result in or be caused by defects in social communication. It is this impairment of contact and communication that appears to be the important factor in adjustment in society" (p. 23).

Anxiety in Interpersonal Relationships

Sullivan (1953) theorized that in their interpersonal relationships individuals develop a pattern of behavior which persists and recurs over time. It may be an action, a feeling, or an attitude. When exposed to persons and situations which cause anxiety, Sullivan believed that individuals develop a self-system to deal with the anxiety; the greater the anxiety, the higher the defenses of the self-system. Sullivan concluded that regressions in personality may occur when pain, anxiety, and failure are perceived as intolerable. Stagner (1961) hypothesized that "anxiety is a major factor in virtually every form of personality breakdown. . . . the problem of anxiety and the problem of conflict cannot be handled separately" (p. 115).

Importance of Personality of Nursing Aides to Quality of Care

The nature of interpersonal relationships within a nursing home environment has a profound effect on both those who work there and those who live there. The

importance of a well-adjusted personality for nursing aides to the quality of patient care has been established (Bagshaw & Adams, 1985-86; Fox, 1982; Linn, Gurel, and Linn, 1977; Mullan, 1961; Stein, Linn, & Stein, 1986). The Committee on Nursing Home Regulation of the Institute of Medicine (1986) summarized that importance: "The dignity with which residents are treated and the friendliness and caring of staff, especially aides, are critical prerequisites to a quality life experience" (p. 382).

In addition to a well-adjusted personality, nursing aides must have a sense of dedication and emotional commitment to nursing home work (Erickson, 1987; Gordon, 1981; Handschu, 1973; Rogers, 1976; Schwartz, 1974; Tellis-Nayak & Tellis-Nayak, 1989). Rogers (1976) noted, "the lack of dedicated, sacrificially motivated nursing home workers will cause the most frustrating experiences to the nursing home administrator" (p. 128). Schwartz (1974) described the embodiment of Frankl's concept of transcendence of self and circumstances,

The best staff people, the most dependable, most prized staff people are those who have captured in some degree the sense of high mission (quality care) within the operation, who have come to understand and appreciate the most exemplary objectives in the care of the aged and who have a deepening sense and appreciation of their own roles, their own contributions and their own importance in the effort to attain such goals. (p. 51)

In a study by Hogstel (1983) of nursing aides in Texas, the factor which aides ranked first in job

satisfaction was that they enjoyed being with older people. Second was that they liked taking care of sick people.

Regardless of any altruistic desire to serve others which aides have, they may bring to their work preconceived ideas about aging, sick older persons, and about nursing homes in general (Winn, Elias, & McComb, 1978). According to Sullivan (1953), we learn to perceive self and others as a result of our interpersonal relationships. The perceptions held by an individual toward other persons Sullivan termed personifications. The way in which one person is perceived may generalize to groups of people. For example, the personification of a parent either as a wise, kindly, protective person or as a dictatorial, harsh, punitive person may project to others in authority or to older persons and color the relationship with that person in the way the parent was perceived. Mental images of individuals or groups of people when held in common by a number of persons are called stereotypes. Stryker (1981) commented on the consequences of negative stereotyping by caregivers such as nursing aides,

An untrained person with positive attitudes toward a particular clientele, especially the disabled and the elderly, often have a more therapeutic effect than a trained person with a negative attitude which may actually cause increased fear or psychological withdrawal by that group of patients. (p. 65)

Using a behavioral observation checklist, Kahana and Kiyak (1984) observed 72 staff members from four nursing

homes. Staff who had direct contact with patients--32 nurses, 30 nurse's aides, 6 professional staff members (administrator, social workers, activity directors) and 4 housekeeping staff--participated in the study.

Participants completed an attitude questionnaire prior to behavioral observations made by trained observers. Results indicated that staff members who saw an older person as an individual and not as a stereotype exhibited more positive behaviors and affect toward patients. The researchers concluded that stereotypes held by a staff member were more predictive of actual behavior with patients than were the staff member's stated intentions of behavior toward patients. Winn, Elias, and McComb (1978) concluded that working in a nursing home may actually increase negative stereotyping of aging and the aged.

In a study involving 469 nursing personnel in 15 long-term care facilities, George (1979) found that, in general, all of the nursing personnel in the study were mildly positive toward older people; however, aides had significantly less positive attitudes than either RNs or LPNs. Winn, Elias, and McComb (1978) also found aides to hold the most negative attitudes toward patients.

Ideological Attitudes Toward Institutional Health Care

Regardless of the personal attitudes of nursing aides toward their therapeutic role in the nursing home, aides must conform to the stated or implied institutional policy

set by management and supervisory staff or leave the job. Regardless of the ideological attitude of nursing home management toward patient care stated in words, that attitude may be negated in practice (a) by the personal qualities and qualifications of the person hired as an aide, (b) by the efficacy of the orientation and training the aide receives in the job, (c) by the number of patients for whom the aide is expected to provide care, and (d) by the rate of absenteeism and turnover in that facility. If the strongest institutional emphasis is placed on fulfilling the bodily needs of patients and the surveillance of mentally confused or wandering patients (a custodial orientation), the aide must conform to those roles. If meeting the psychosocial needs of the patient while tending the bodily needs is emphasized (a humanistic orientation), time must be allowed in the aide's proscribed institutional role to allow a warm supportive interpersonal relationship to develop between patient and aide (Tellis-Nayak & Tellis-Nayak, 1989).

Humanistic vs. Custodial Role of Aides

Bagshaw and Adams (1985-86) posited that nursing homes are oriented either toward a therapeutic humanistic philosophy of care or toward a custodial philosophy. The researchers defined a custodial environment as a highly controlled and task-oriented environment with strong emphasis on the physical maintenance and safety of patients

and little attention to rehabilitation and optimal functioning of the patient. They defined a therapeutic environment as one in which the attitude toward patients "fosters optimal physical, psychosocial, and social functioning, primarily through humanistic, therapeutic, interpersonal relationships" (p. 237).

Bagshaw and Adams studied 62 RNs, 62 LPNs, and 239 nursing aides in seven nursing homes relative to variables of attitudes, empathy, and ideological orientation toward either custodial or therapeutic treatment. The researchers found that less empathic staff were more oriented toward custodial treatment and also held more negative attitudes toward the elderly. Nursing aides were found to be significantly less empathic, more negative, and more custodially oriented than were RNs and LPNs. The researchers commented that, although the analyses of the differences were beyond the scope of their study, there were significant differences found among subjects by nursing home in scores on empathy, attitudes toward the elderly, and ideologic orientation toward treatment. They postulated that these differences related to the psychosocial climate of the particular nursing home in which subjects worked. Tomine (1986) concluded that "nursing home care givers may also suffer the added stress of role confusion because of the ambiguous philosophy

regarding custodial-therapeutic treatment in that setting" (p. 64).

To investigate the interaction effects between personality and occupational role, Berk and Goertzel (1975) studied all psychiatric aides hired during a five-month period in a 5,000-bed mental hospital. The aides were tested on their opinions about mental illness on their first day of employment and again six months later (following a compulsory training program and after aides were working on the wards). The aides were tested a third time at the end of the year. The purpose of the study was to examine factors related to the opposing philosophical tendencies in health care institutions toward either custodialism or humanism. The study is relevant to nursing homes because of (a) the large number of nursing home patients with mental or behavioral problems; (b) the similarity of the position of the nursing home aide and the psychiatric hospital aide in the organizational hierarchy of the facility; and (c) the dissimilarities between the professional nursing staff and the aide staff, which are characteristic of both institutions.

Berk and Goertzel (1975) found that a similarity in the personalities of persons occupying similar occupational roles can be brought about by (a) primary self-selection (similar types of persons apply for a job), (b) primary organization selection (organizations hire those with

characteristics compatible with the objectives of the organization), (c) secondary self-selection (certain types of persons choose to remain in the organization and those who are dissimilar drop out), and (d) secondary organizational selection (the organization encourages certain types of persons to leave, or fires them).

Results of the study suggested that all four phases of the selection process as well as role occupancy contributed to role-related attitudes of aides. The researchers examined the effects of role occupancy on aides in the socialization process within the organization (grades, promotions, raises, performance ratings) and length of time in the role. They found that, in the training program, humanistically oriented aides received higher grades than custodially oriented aides; however, in evaluations of performance on the wards, the custodially oriented aides received higher performance ratings. Testing at the end of a year of role occupancy indicated a marked increase in custodial orientation among the aides. Results of the study indicated that both selection and role occupancy contributed to role-related attitudes. Selection out of the organization (either by self-selection or by the choice of the organization) of persons with a humanistic treatment orientation increased the custodial orientation among those who remained in the role. The researchers noted that, although the majority of aides became more custodially

oriented, a few aides retained or increased their humanistic orientation. This result indicated, according to the researchers, that attitudes held by aides are influenced by attitudes held by other staff with whom they are closely associated.

Pennington and Pierce (1985) conducted a study of empathy among 125 staff members in 11 nursing homes. Nursing aides comprised 39% of the participants in the study; 29% were from the professional nursing staff; other participants were from 16 different work categories in the 11 nursing homes "from social workers, to secretaries to kitchen helpers" (p. 284). Displays of empathy by participants in their interaction with patients were evaluated by trained observers, using a standardized instrument. Number of years in the field and age were found to be the highest predictors of empathy. Staff members with more than one year of experience and up to 5 years of experience exhibited a high level of empathy; those with 6 to 10 years of experience showed little empathy. The researchers suggested that this finding may indicate that over a period of time longer-tenured staff may invest less emotional energy in their relationship with patients in order to cope with job-related anxieties, reflecting a combination of burn-out and self-selection. Pennington and Pierce also commented that staff with limited capacity for empathy may have self-selected

themselves out of the occupation earlier. Younger staff were found to have the highest degree of empathy and older staff the least. An explanation offered for the finding was that older employees feel considerable empathy but fear becoming like the dependent older person so do not display empathy.

Contributors to Job-Related Anxiety Among Nursing Aides

For nursing aides the anxiety of working in a nursing home is compounded not only by the day-to-day pressures of providing care to older persons with multiple physical problems, probable mental impairment, and fragile emotional stamina, aides must also cope with negative attitudes from outside the nursing home which intrude in the nursing home milieu. These attitudes are generated by the historically negative public attitudes toward nursing homes, the intense pre-admission stress often experienced by patients, and the maladaptive family/patient relationships which may take place before and after a patient is institutionalized.

Negative Attitudes Toward Nursing Homes

To understand the negative feelings of residents, families, and society in general toward nursing homes and the impact of these attitudes on nursing aides, it is necessary to consider the history of nursing homes. Additionally, it is necessary to review some of the historically negative attitudes toward the nursing home

concept held by the general public and by persons facing institutionalization.

Historical antecedents. During the 1800s the care of blind, chronically ill, indigent, mentally ill, or retarded persons was considered to be a local problem (Schachter, 1974; Vladeck, 1980). If the family could not care for them, or there was no family, they became wards of local government. They were housed together without consideration for age, mental status, or type of incapacity. Institutions for housing them were called almshouses, poor houses, or poor farms. The reputation of these institutions was so unsavory and the stigma attached to living in them so great that the threat of being sent to one was enough to fill anyone with dread (Stewart, 1925).

During the late 1800s and early 1900s ethnic immigrant groups and religious organizations established charitable private homes for their aged. They were the forerunners of today's non-profit nursing homes. Other destitute elderly, as well as the mentally or physically ill, continued to be cared for in almshouses, asylums, and hospitals, or in private proprietary boarding homes for those able to pay (Vladeck, 1980). Litman (1974) noted that the licensing in 1917 of Connecticut's first convalescent facility was the beginning of efforts to abolish the farming out of aged and indigent persons to the lowest bidder.

With the enactment of the Social Security Act of 1935, the long-term care industry in the United States received an indirect incentive for its expansion. For the first time in American history, qualified persons, age 65 and older, were guaranteed a monthly income. The ability of more older persons, by means of Social Security, to support themselves financially also enabled them to pay for personal care in old age. "Home" for the elderly often became boarding "home," rest "home," convalescent "home," or nursing "home," as they are euphemistically labeled in our society. In 1965, the Social Security Act of 1935 was amended by two major pieces of legislation. Title XVIII, Part A and B (Medicare) and Title XIX (Medicaid) were enacted to help older persons afford the increasing costs of health care. This legislation marked a shift from a social philosophy which held the individual or the immediate family responsible for the medical care of the aged and chronically ill to a philosophy which holds society responsible for that care (Litman, 1974).

One of the first inventories of nursing homes was a 1939 study on institutional mortality by the Bureau of the Census which counted 1,200 facilities (Special Committee on Aging, 1974). The 1985 National Nursing Home Survey reported a total of 19,100 nursing homes with 1.5 million residents (Strahan, 1987).

Attitudes held by the general public. The concept of institutional care for those unable to care for themselves has become more acceptable and more essential in our society. There are several reasons for this change in attitude. Society has become more mobile. Family members may be geographically dispersed and their caregiving less available on a day-to-day basis. More women who were potential caregivers for older family members have entered the work force. Lower birth rates have produced smaller families with fewer siblings to share in the responsibilities for parental care. Increased longevity and later onset of debilitating infirmities and disease mean that children of elderly parents are also older and less physically able to provide nursing care for parents at home. In addition, more sophisticated nursing skills and the use of more complicated technical medical equipment needed for patient care are beyond the medical knowledge of most family caregivers (Palmer, 1985).

The increased need for and use of institutional care has not changed public sentiment toward its use, however. Atchley (1980) noted that negative feelings about old-age institutions are still influenced by the concept of the poor house, which has survived from an earlier era. Other images more recent than those of the poorhouse are also seen to be negative.

The negative image and malignment of the nursing home industry has been due in significant measure

to the fact that until the 1960s many, if not the majority, of facilities throughout the country were providing substandard levels of care. . . . There is little question that numerous institutions have served as tragic dumping grounds for persons who were not provided with reasonable alternatives for placement. (Levey, Stotsky, Kinloch, Ruchlin, & Oppenheim, 1975, p. 66)

Kane (1985, p. 23) contended there is an incongruity between federal and state policy which supports nursing homes ("to the tune of at least \$12 billion a year") and the nation's social values, which espouse the collective obligation of citizens to provide older persons with a measure of independence, privacy, and dignity.

Nursing homes, next to hospitals representing the largest public investment in services to older persons, exact an intolerable price (in dollars and misery) for their users. Suffice it to say that one of four persons who lives to 65 will enter a nursing home; that almost all who retain cognitive abilities will be terrified and desolate beforehand, and all too many will be bored and demoralized afterward. It is simply unconscionable that our public policy is built on an institution that, as presently constituted, is so unacceptable to the consumer. (Kane, 1985, p. 23)

Preadmission attitudes of patients. Generalized negative social attitudes toward nursing homes become intensely personal and painful ones when a decision is made by an older person and/or the family that institutionalization is necessary. The attitude of the patient toward being institutionalized largely determines the way the patient adapts to the institution and is one index of the amount of stress in the aide/patient

relationship. Fears of being institutionalized are related to feelings of being rejected and abandoned by family, to a perceived loss of personal independence, and to a belief that entry into a nursing home foreshadows impending death (Atchley, 1980; Dobrof, 1979; Moore, 1986; Ruben & Byrnes, 1977; Savitsky & Sharkey, 1972; Tobin & Lieberman, 1976). Becoming institutionalized is, in fact, a grieving process (Reimann, 1986).

Fears of rejection and abandonment. Perhaps older persons have an intuitive sense of rejection by their families. Krause (1982) discussed changes in the American family structure and the nature of life in an industrial and fast-paced society.

The contemporary family structure can be viewed as promoting the institutionalization of the elderly; it is not important whether the intention is explicit, because the effect is the same (p.95). . . . Few families are willing to accept the restrictions on mobility, privacy, and independence that accompany the introduction of an older person into a household. (Krause, 1982, p. 97)

Fears of parents that they have been abandoned in old age by their children largely depend on their expectations of care. Women are more likely than men to expect their children, particularly daughters, to care for them (Seelbach, 1977). Expectations by parents that their children will provide parental care in old age serve to increase the children's sense of guilt and heighten the

parent's feelings of rejection when institutional placement is made.

Loss of decision-making role. One of the most pervasive of the fears of being placed in an institution is that of loss of control over personal decisions. This is not an unrealistic fear. George (1980) noted that the overwhelming majority of moves to an institution are involuntary and therefore more likely to be stressful and to have a negative impact on the resident's well-being. York and Calsyn (1977) found in their study of 76 patients and their families that decisions about institutional placement are usually made by an adult child. Advice from physicians was listed by 83% of the families as being an important factor in the decision.

The failure of most families to involve the patient and the nursing home staff in the decision to place the patient would seem to increase the risk of future unhappiness on the part of the patient and subsequent management problems for the nursing home staff. (York & Calsyn, 1977, p. 502)

According to Wack and Rodin (1978), loss of the decision-making role is reinforced by the nursing home environment; dependency is fostered and efforts to assert independence often result in the patient being labeled "difficult."

Fears of impending death. The belief that entry into a nursing home foreshadows impending death is not without at least some basis (Atchley, 1980).

Older people fear nursing homes largely because they fear the influence of the Home on their

chance of survival--and it appears, with good reason. Mortality rates for older people in institutions are higher than those outside, particularly during the first year. This situation, of course, exists partly because sickness often prompts the move to a nursing home in the first place. (p. 123)

How and by whom the decision is made concerning institutionalization has impact on satisfaction and survival in a nursing home. Noelker and Harel (1978) found the percentage of deaths after two years of institutionalization to be twice as great among those who wanted to live elsewhere as compared to residents who desired to live in the facility.

Maladaptive Patient/Family Relationships. Family conflicts over the institutionalization of a family member often overflow to the nursing home and may be vented on nursing home staff (Duffy & Shuttlesworth, 1987; Jordan, 1983; Montgomery, 1983). The decision to place a family member is not made lightly and can be traumatic (Hatch & Franken, 1984; Manning, 1985). Cath (1972, p. 26) called the experience a "nadir of life" and posited that family conflicts aroused by the decision can cause family members to establish barriers of hatred between themselves that are never resolved, or the decision can lead to stronger family bonds.

Feelings of love, sadness, helplessness, resignation and guilt are emotions common to adult children when a family member is institutionalized (Hatch & Franken, 1984;

Sancier, 1984). Brody (1966) considered a sense of guilt on the part of children to be reinforced and intensified by our culture. Jordan (1983) concurred, "Our society has placed an unbearable weight on family members who place a parent in a nursing home" (p. 171).

The impact of institutionalization is felt by the whole family (Brody & Spark, 1966; Lissitz, 1962; Woehrer, 1983). According to Jordan (1983), the primary responsibility of a nursing home is to the patient, but there is also an obligation to families because both patient and kin are an inseparable part of the social network of the facility. This relationship may be difficult. Families may assuage feelings of guilt by becoming overly protective of the family member in the nursing home and extremely critical of the care given, or by being absent and nonsupportive (Tomine, 1986). Silverstone and Hyman (1976) discussed maladaptive family behavior and its effect on both patients and staff,

Families resort to demanding behavior just as frequently as their resident relatives. They may disguise their demands by being over-solicitous, by incessant visiting, and by constant complaints and interference with the staff, all of which may put an undue emotional strain on their own relatives Excessive behavior from families is as destructive as excessive behavior by residents and becomes even more destructive if the staff gets drawn in. (pp. 232-233)

Kramer and Kramer (1976) believed that patient/staff relationships in long-term care facilities parallel family relationships with the same range of emotions. They noted

that the emotions are generally cumulative and then erupt out of proportion to the triggering incident. The person who is overreacting is usually re-experiencing attitudes, feelings, and behavior from past family relationships and the feelings expressed are generally negative.

When family dynamics are examined in terms of their meaning for nursing home staff, it is obvious that the brunt of the negative attitudes of families is borne by nursing aides who come in contact with families more often than do other staff members. Aides report dealing with patient families to be one of the frustrating aspects of their job (Fisk, 1984; Hogstel, 1983; Schwartz, 1974).

There is a fine and subjectively drawn line between vigilant and necessary family awareness of the care a relative receives and the excessive fault-finding of a guilt-ridden family in conflict. The counterpart of querulous residents and complaining families are those residents and families who are so compliant or so intimidated that they do not make legitimate complaints. Without legitimate and needed family involvement in nursing homes the quality of patient care diminishes (Jones, 1982; Silverstone & Hyman, 1976). Benefits also accrue to patients and to the nursing home as a result of considering the family an additional resource for improving patient care (Hogstel, 1983; Litwak, 1979; Montgomery, 1983; Rubin & Shuttlesworth, 1983; York & Calsyn, 1977).

Conditions of the Work-Place Environment

The role of nursing aides in the nursing home, by virtue of the fact that they provides most of the direct patient care and are the most accessible staff members to the visiting family and the general public, places aides in a position to bear much of the public antipathy toward nursing homes. In addition to negative attitudes toward nursing homes held by the general public, by the individual who faces institutionalization, and by their families, there are also areas of interpersonal relationships specific to the nursing home environment which can contribute in substantial ways to exacerbate any tendency to personality maladjustment and anxiety-proneness. Among these areas are low staff morale, aide/patient relationships, intrastaff conflicts, management of emotionally disturbed patients, and frequent deaths among the patient population (Cohen-Mansfield, 1989; Thoreen, 1983).

Low Staff Morale

Stryker (1981) proposed that the negative image of nursing homes caused by the poor practices of some, which were widely publicized by the media, has had a negative impact on the self-esteem of nursing home employees and has made it more difficult to attract and retain good staff. George (1979) observed, "either a survey of relevant literature or conversation with the administrators of

nursing homes generates the same conclusions: the two greatest problems with staff at long-term care institutions are morale and turnover" (p. 1).

The negative stereotyping of nursing homes and those who work there has its greatest impact on nursing aides (Vladeck, 1980). Negative public attitudes may be reinforced by negative self-perceptions among many aides caused by low educational achievement and low family socioeconomic position, often compounded by a minority status. The effect of any of these negative self-perceptions impacts on the aide's work attitudes and interpersonal relationships (Goldin, 1985; Handschu, 1973; Henderson, 1987; Stannard, 1976).

Job Perceptions of Nursing Aides

Molberg (1978) studied the job perceptions of 278 nursing aides. Younger aides had less overall satisfaction with their jobs. They had a greater tendency to feel depressed by working with sick older persons and more often felt their work was uninteresting, physically and emotionally difficult, and viewed as unimportant by the public.

Henderson (1987) found in a survey of nursing aides in a 90 bed nursing home that 60% of the aides ranked their importance as below average compared to other staff members. Fox (1982) believed that low self-esteem is

rampant among aides and that it can, and often does, lead to physical or verbal abuse of patients.

Low self-esteem is exacerbated by the nursing home environment, in part, because those most affected by the care given by the aide, however tender and kind it may be, often do not express appreciation (Gordon, 1981). In many instances the patient is not cognitively functioning enough to be able to express gratitude. In other instances the anger and fear of the patient at being institutionalized, along with the guilt and stress felt by the family, is displaced to the aide and does not allow the patient or the family to be objective enough to appreciate the efforts of the aide. According to Gordon, nursing home employees, in general, tend to need a great deal of recognition and appreciation because there are few tangible ways for them to measure the quality of their work. Aides particularly need recognition (Erickson, 1987; Goodwin & Trocchio, 1987; Henderson, 1987; Hogstel, 1983; Mullan, 1961). The aide's perception of a lack of appreciation shown on the part of management is cited as a possible cause of job turnover among aides (George, 1979; Rogers, 1976).

Aide/Patient Relationships

Krause (1982) considered the single most disturbing feature about long-term care institutions to be the control they exert over patients. As detrimental as this control is to the self-esteem of female patients, it is even more

devastating to male patients (Kramer & Kramer, 1976).

Stein et al. (1986) studied 111 patients from admission to three months afterward. The researchers concluded that the longer a patient lives in a nursing home, the more important patient/staff interpersonal relationships become. They also found that even in nursing homes providing what the researchers judged to be excellent care, the level of stress in staff/patient interpersonal relationships increased over time.

Vladeck (1980) discussed a component of the aide/patient relationship: "In inner cities, the work force is heavily black and Hispanic, often adding another element of potential hostility to the highly charged relationship between residents and aides" (p. 21). Browne (1986) also addressed the issue of the polarization of the white patient and the non-white aide, which he believed to be pervasive in long-term care institutions.

When the institutionalized aged, middle class, white client and the poor, black paraprofessional worker encounter one another, spontaneous expressions of distress stemming from associated fears, suspicion, distrust and hatred frequently become activated. (Browne, 1986, p. 6)

According to Wack and Rodin (1978), another source of aide/patient conflict arises because nursing homes are based on a medical model of care which focuses on physical limitations rather than on compensating strengths and adaptive resources of patients. This attitude pervades the

environment and sets the tone for the type of interpersonal relationships that develop.

Most of the residents' contact with staff is with low-paid, poorly educated paraprofessionals [aides] who perform custodial functions such as bathing, dressing, and assistance in using the toilet. They see the residents at those times when they are indeed most dependent and develop attitudes and behavior toward them that are often authoritarian and condescending. (Wack & Rodin, 1978, p. 15)

Turner, Tobin, and Lieberman (1972) studied 85 older persons waiting to be institutionalized. They were all ambulatory, cognitively functioning, and free of major incapacitating illnesses. They were studied three to twelve months before admission and one year after admission to assess how they had adapted to institutional life. For those remaining in the study after one year of institutionalization, the researchers found that the particular trait factor associated with successful adaptation was "loaded highly on activity, aggression, and narcissistic body image. This cluster of traits suggests that a vigorous, if not combative, style is facilitory for adaptation" (p. 67). It is apparent from this study that the traits which may facilitate resident adjustment to living in a nursing home are those traits which make the job of caring for patients more difficult for aides.

The testimony of an 81-year-old nursing home resident provides insight from a person who has experienced adaptation first-hand.

And why do people often become difficult? Of course, medical reasons enter into it. But for one to feel oneself cut off from the mainstream of life so that life has turned into a plan where one no longer is in control of living situations, where all daily activities are planned by others so that one's world shrinks smaller and smaller until the world is pretty well contained in however many feet surround the bed--well that has to be experienced to be understood. Perhaps some stubborn resentment on the resident's part is not basically directed at the nurses caring for them, but may just be a final act of rebellion at letting go of the little control of life she still wants to have left. (Armstrong, 1984, p. 38)

Intra-staff Conflicts

Differences in ethnicity and social background between aides and patients are often true of aides and supervisory staff. This increases the possibility of incompatibility between the professional nursing staff and the paraprofessional staff which often affects their working relationship (Friedsam, 1974; Hogstel, 1983). Kramer and Kramer (1976) noted that "the longer we work in geriatrics the more obvious it becomes that interpersonal relationships among the staff are extremely important" (p. 215). They postulate that intra-staff frictions trigger symptoms in patient behavior which subside if tensions are resolved.

Nursing aides are relationship-oriented (Gordon, 1981; Brannon, Smyer, Cohn, et al., 1988; Erickson, 1987; Gordon, 1981; Holtz, 1982). Holtz surveyed 31 nursing aides from three nursing homes who had worked for one year in that facility to identify factors which the aides considered to

be important to remaining on the job. Interpersonal relationships--getting along with patients, supervisors, and co-workers--were rated as most important by 100% of the aides. In interviews with 30 aides from two nursing homes Fisk (1984) reported that, with few exceptions, intra-staff conflicts was identified by the aides as one of the two most frustrating aspects of their job (family members who complained or visited the patient infrequently was the other). Kasteler, Ford, White, and Carruth (1979), in a study involving 426 former nursing home employees, reported that intolerable interpersonal relationships and disenchantment with the management of the home were among the reasons given by the former employees for leaving the job.

Emotionally Disturbed Patients

Another of the interpersonal relationships which can create anxiety for the aide is the presence in the nursing home of large numbers of retarded or mentally disturbed patients. Tomine (1986) stated, "Major concerns identified in interviews with nursing home administrators included high staff turnover, time-consuming interactions with families in crisis, and ineffective management of depressed and demented residents" (p. 406). Dunlop (1979, p. 35) considered that a "substantial portion" of the increased utilization of nursing homes during the period 1964-1974 was due to the fact that nursing home care replaced other

types of institutional care for the elderly. The advent of psychotropic medications and mood altering drugs brought about the release from mental institutions of many older persons who had been considered to be mentally ill. Deinstitutionalization of the mentally retarded soon followed. Many of these people were released to foster care homes and later moved to nursing homes.

Johnson and Grant (1985) estimated that two-thirds of nursing home residents have some form of behavioral impairment and posit that the nursing home has become a substitute for the mental hospital. Safford (1980) estimated that at least 50% of those residing in long-term care facilities suffer from moderate to severe mental impairment. Moss and Halamandaris (1977) cited a 55% rate. According to the 1985 National Nursing Home Survey (Hing, 1987), 63% of residents were disoriented or memory-impaired to the degree of being unable to remember dates or time, unable to identify familiar people or locations, and unable to make straightforward judgments.

Because of the generally limited education among aides, they may lack even rudimentary knowledge about how to care for mentally and emotionally impaired patients. Aides must rely on their own inventory of coping skills to manage confused, disoriented, and wandering patients who have no memory of how to dress themselves, where they are, where their rooms are located, where there is a restroom,

or where they go to eat. Aides must cope with agitated and combative patients with chronic dementia and other forms of mental illness. If the aide does not know how to work with these patients, both the aide and the patient are placed in danger (Johnson-Pawlson & Goodwin, 1986). Stannard (1976) believed that control of such patients is one of the most difficult problems for aides and that aides often use abuse to cope with it. When the aide experiences anxiety and frustration under these circumstances, it is communicated to patients, exacerbating the problems for them both and increasing the potential for patient abuse. In addition, if the aide is maladjusted and highly anxious, problems for both aide and patient are compounded.

Death of Patients

Staff/resident interpersonal relationships are critical in nursing homes because the quality of that relationship is so important to the dying patient (Grau, 1983). Personal attachments which occur in most relationships where care is given and received are often shortened in nursing homes because of death. But even short-term attachments cannot be discounted as to their genuine effect on the anxiety level of nursing personnel.

Because aides give most of the direct care to patients, it may be inferred that they also spend more time than other staff tending the dying patient. Witnessing death is a profound experience, regardless of how many

times an aide has had that experience. The role of the aide in providing a measure of emotional as well as physical comfort for dying patients is stated poignantly by an aide in a letter cited by George (1979). "Many times one who is terminally ill will ask you if you will hold his hand while he dies. This is both the least and the most you can do for him" (p. 58).

Thoreen (1983) estimated that 20% to 25% of persons living until age 65 will die in a long-term care facility. Other researchers support this estimate (Ingram & Barry, 1977; Kastenbaum & Candy, 1973; Palmore, 1976).

Many of the nursing staff in nursing homes have difficulty facing thoughts of their own aging and mortality, making it difficult for them to care for dying patients and to accept their deaths (Helper, 1987; Thoreen, 1983). When looked at from a medical model of care, death is seen by medical personnel as failure and the dying person may be avoided or neglected (Ingram & Barry, 1977). Even with the seeming removal of many of the taboos surrounding the subject of death, Ingram and Barry did not feel that the new attitude has genuinely affected the way staff in nursing homes respond to the dying patient.

Howard (1974) studied the attitudes toward death of 28 nursing aides from seven nursing homes and concluded that work experience in a nursing home encourages avoidance of death and dying persons. Hogstel (1983) found in a survey

of 33 aides that they listed among their priority educational needs learning more about how to care for dying patients. Payne and Lyons (1987) reported that over half the students in a class for aide certification listed coping with the dying person as an objective for the course. Molberg (1978) found that depression over the death of patients is one indicator of the aide's likelihood of leaving the job.

Job Instability Among Nursing Aides

Because a nursing home is an environment involving complex emotional and interpersonal relationships, it is difficult to isolate factors which have a decisive effect on why some aides work only a short time and others continue to work for years in that setting.

Length of aide job tenure has impact on every aspect of nursing home management--including fiscal management and personnel management. Negative aspects of job turnover include the time and expense for recruitment, selection, and training of replacement aides, the pressure on management to maintain proper staff/patient ratios required by regulatory agencies, and the additional burden of work and patient care placed on other staff members. A high turnover rate can exacerbate the job-related anxiety of the longer-tenured aides because it means heavier work loads caused by frequent staff shortages, large numbers of inexperienced aides, as well as aides who have worked in

other nursing homes but who are unfamiliar with the patients, rules, and routines of the facility in which they are now working. Often much of the orientation and training of new aides is added to the work load of longer tenured aides (Halbur, 1982; Stryker, 1981).

The most detrimental effect of turnover among aides, however, is on patient well-being because it deprives the patient of the advantages inherent in continuity of care (Waxman, Carner, & Berkenstock, 1984; Wright, 1988). The continuity of care given by a compassionate aide is very important because of the importance of mutual trust and affection, knowledge of mental and physical functioning, awareness of likes and dislikes, understanding of family background and relationships--all facets of an aide/patient relationship built over time.

Studies of turnover in nursing homes have dealt mainly with problems concerning management, supervision, job orientation, inservice training programs, wages, fringe benefits, and other job-related characteristics (Bales, 1975; George, 1979; Halbur, 1982; Handschu, 1973; Pecarchik & Nelson, 1973; Kasteler, Ford, White, & Carruth, 1979; Tynan & Witherell, 1984; Winston, 1981; Waxman et al., 1984). No studies were found in the literature which related personality adjustment and levels of anxiety among aides to their age, length of time worked in nursing homes, and the number of nursing home in which they have worked.

Age is accepted in the literature as being strongly correlated with turnover. Aides are also more likely to leave the job if they are single (unmarried, divorced, widowed) or plan to further their education. To these characteristics are added being male (Miller, Barry, & Ready, 1976; Molberg, 1978); working part-time (George, 1979; Miller, Barry, & Ready, 1976); and holding two jobs (Molberg, 1978).

Handschu (1973) suggested that greater commitment to work in a nursing home may be an explanation of why older aides tend to have longer job tenure than younger aides. Older aides may be able to accept with more equanimity the pain and suffering which life can bring to all ages (Thorson & Powell, 1988). Younger aides may simply be overwhelmed by the scope of the mental, emotional, and physical problems with which they are expected to cope.

Wallace and Brubaker (1984) analyzed job application forms of 103 currently employed aides and 459 aides who had left their jobs. From the information available to the researchers it was not possible to distinguish between those who left voluntarily and those who were fired. Factors found to be associated with an aide remaining on the job were being older, having more dependent children, living closer to work, having worked longer on the previous job, and having worked more months as a nursing aide. A three-and-a-half-year mean difference was found in the mean

length of employment between aides who left and those who stayed.

Wagnild and Manning (1986) interviewed 33 aides from 11 randomly selected nursing homes who had worked at least 12 months in their job and 40 aides who had left their jobs within a 12-month period. They found that aides with tenure of longer than one year tended to be older, to have less education, and to have worked in fewer nursing homes. Nine of the 33 aides with more than one year's tenure had never held a previous job. Aides who had held a previous job were more likely to have had longer tenure in the previous job. Aides with tenure of longer than one year in the present job had an average of about five years experience in the job. Aides who had left their job averaged less than seven months on the job, had worked in two or more nursing homes within a three-year period, and had averaged less than 18 months in previous positions. Those who had left their job were generally less than 28 years of age and likely to be single with fewer family ties.

Molberg (1978) found in a study of the job perceptions of 278 aides that younger aides were less satisfied with their salaries and fringe benefits and had held more jobs over the last five years than had older aides. Miller, Barry, and Ready (1976) surveyed 74 nursing home personnel as to reasons for staying on the job. Of those personnel

in direct contact with patients, 24% attributed their staying to the patients, 24% to a sense of satisfaction at the end of the day, and 20% to the relationship with their coworkers.

Holtz (1982) surveyed 31 nursing aides from three nursing homes who had worked for one year in the facility and asked them to identify 10 factors which they considered to be important to remaining on the job. Interpersonal relationships--getting along with patients, supervisors, and co-workers--were rated as most important by 100% of the aides. Ranked in descending order of importance by aides were supervision, achievement, and responsibility (90%); enjoyment of the work itself (84%); salary, recognition, and administrative policies (74%); working conditions (68%); and advancement (48%).

Researchers have found that nursing home aides generally work for a few months and quit, or continue to work for extended periods of time (George, 1979; Halbur, 1982; Molberg, 1978; Rublee, 1986; Wallace & Brubaker, 1984). Rublee (1986) conducted a personnel analysis of 397 employees (from service, technical, clerical, and nursing services) at five nursing homes. One year later 340 employees at the five facilities were again surveyed. The nursing homes provided a list of employees who had terminated during the interim between surveys. From this information an assessment was made of the extent to which

turnover was predictable. Predictors of actual turnover were age and tenure (younger and shorter-tenured employees were most likely to quit). Overall dissatisfaction with the work, supervisors, coworkers, pay and promotion were found to be strongly related to thoughts of quitting and to intentions to quit, with the best predictor of turnover being intentions to quit.

A study of turnover in 87 nursing homes in Utah was conducted by Kasteler, Ford, White, and Carruth (1979). Information was obtained from 426 former employees and 83 nursing home administrators. Former employees said they found the work to be mentally and physically exhausting, dirty with accompanying unpleasant odors, and depressing. They were disappointed that they could not do more to help patients. Low pay, long hours, limited promotion opportunities, few fringe benefits, understaffing, intolerable interpersonal relationships, and disenchantment with the management of the home were other reasons given for leaving. The researchers noted that a fairly large number returned to unemployment status because they preferred it to nursing home work. The administrators reported that approximately 20% of the former employees had been fired.

Halbur (1982) took a structural approach to examining turnover in 122 nursing homes in North Carolina and concluded that the job opportunity structure indicated by

the unemployment rate in the county where a nursing home was located was the most accurate predictor of turnover for all levels of nursing personnel. For nursing aides, turnover rates increased approximately 56% when there was increased opportunity in the job market. Halbur suggested that aides may go to occupations other than health care when better pay and benefits are offered. She noted, "While this study and others in the meager literature have demonstrated that higher wages may not be the key to reducing turnover, poor wages can certainly increase turnover" (p. 53).

Cooney (1986) remarked that the pay of nursing aides "throughout the industry, with few exceptions, represents a scandal" (p. 39). Cooney contended that many others are drawing "comfortable levels of living and goodly measures of profit. . . . from the sweat of nurse assistants' brows" (p. 40).

Waxman, Carner, and Berkenstock (1984) conducted research in seven randomly selected nursing homes in Philadelphia. Interviews and questionnaires were used to collect data from 234 aides from the day and evening shifts. Turnover was examined in terms of wages and benefits, job satisfaction, and perceptions of the institutional atmosphere. A rank-ordering was made as to the overall quality of the nursing homes in terms of physical plant, administrative operation, programs, and

patient care. The researchers concluded that turnover problems appeared to be greater in higher quality nursing homes and that there was no relationship between high rates of turnover and the amount of wages and quality of benefits offered by the homes. Concerning job satisfaction, the researchers found turnover rates were lowest in homes where aides voiced the most complaints and highest in homes where aides claimed greater job satisfaction. From the results of the study the researchers concluded that turnover among aides is more influenced by management style practiced by supervisors than by wages and benefits.

It cannot be inferred that all of those who remain employed in nursing homes for longer periods of time have well-adjusted personalities and a sense of commitment and purpose. Some aides with longer tenure may be maladjusted persons who find in the aide/patient relationship the opportunity to exert an authoritarian role and to vent aggressive behavior. Aides may also succumb to inertia and lack motivation to change jobs. Miller et al. (1976) found in their study that three of six long-term employees had an inability to grow in the job and that longer tenure did not necessarily represent successful employment experience. Prien and Cassel (1973) cautioned that "employees who cannot financially afford to be physically absent may still be psychologically absent" (p. 39).

Although there are very negative outcomes of high rates of turnover for patients, staff, and management, there are also positive aspects to reasonable amounts of turnover. According to Halbur and Fears (1986) and Stryker (1981), when employees who are abusive to patients or are unable to meet new standards of job performance leave, morale rises among patients and staff; leaving prevents those who are unwilling to accept innovative ideas or changes in regulations from being a hindrance to progress in patient care; others who find nursing home work unrewarding or depressing and who perform their tasks perfunctorily and without compassion improve the therapeutic milieu by leaving.

Summary

Literature related to nursing homes indicates that a requisite to optimum patient care is a nursing aide with a well adjusted personality and a commitment to empathic care of older persons. Sullivan's concept of anxiety as a result of interpersonal relationships, particularly those relationships involving criticism and disapproval, offers a theoretical framework for viewing the psychosocial influences in the nursing home milieu. According to Spielberger (1983), high levels of anxiety for an individual also indicate personality maladjustment. Both personality maladjustment and elevated levels of anxiety

may directly affect the job performance and length of employment of nursing aides.

However, to consider only the personality adjustment and anxiety level of the nursing aide and their impact on the nursing home milieu is to look at only one aspect of a complex relationship. There are other important aspects. Observers note that the historically negative attitudes held by the general public become intense for older persons as they face the reality of institutionalization. In addition, maladaptive preadmission patient/family relationships can be so intrusive in the nursing home environment that they create problems for the nursing staff, and particularly for the nursing aide, to whom these negative feelings may be transferred. Because aides provide most of the direct patient care, they also have the most contact with families. This situation places the aide in a vulnerable position in the nursing home organizational hierarchy as a scapegoat both for patients and families and for supervisory and administrative staff. Such a position makes aides vulnerable to the psychological failure which Argyris (1976) theorized occurs among low-level employees in an anxiety-inducing work situation.

Working with large numbers of mentally disturbed or dying patients also creates anxiety for aides. Another area of anxiety for both aides and patients centers around personal control. When patients try to retain some measure

of personal control in an environment based on a medical model of care where control is vested in medical and administrative staff and implemented by nursing aides, an adversarial relationship between aides and patients often develops.

It is evident from the literature that a nursing aide with a well-adjusted personality is crucial to a therapeutic nursing home environment which attempts to meet the psychosocial needs of patients as well as providing for their bodily needs. However, a review of the literature related to nursing homes indicates that researchers have not focused on the personality adjustment and anxiety level of aides and how these factors may relate to job stability among nursing aides. This neglect seems crucial.

CHAPTER III METHODOLOGY

Overview

This research focused on the personality adjustment and anxiety level of nursing aides currently employed in selected nursing homes and related these factors to demographic and work-related variables. This information expands the limited knowledge now available to nursing home administrators and directors of nursing concerning criteria for more effective selection, training, and retention of nursing aides.

Nursing Aide Population

Nursing aides have a unique and important relationship to the quality of care--both physical and mental--of nursing home patients. According to data from the 1985 national nursing home survey, there were 501,000 full-time-equivalent nursing aides and orderlies employed in nursing homes. They comprised 71% of the total nursing staff (Strahan, 1987).

In a 1977 national nursing home survey, the authors indicated the average age of nursing aides was 34 years; approximately 93% were women; about 33% completed less than 12 years of education; almost 75% were white (including

Hispanics and other minority Caucasians); approximately 21% were black; and average total work experience of full-time aides was 5.2 years, with 3.2 years in the current job (Sirrocco, 1981). Waxman, Carner, and Berkenstock (1984) studied 234 aides in seven nursing homes in Philadelphia: demographic information showed the mean age was 33.8 years; 95% were female; 65.4% were black; 28.2% had not finished high school.

The 124 aides in the present study had a mean age of 33 years; 91.9% were female, 8.1% were male; 86.3% were black, 13.7% were white; 63.7% had worked one year or less in the current job; and 51.6% had worked 6 months or less. Among the aides, the average total work experience in nursing homes was 3.9 years; the median was 2.2 years. The average number of nursing homes in which the aides had been employed was 2.4; the median was 2 nursing homes.

Selection of Subjects

The sample for this study was drawn from nursing aides currently employed in five nursing homes in North Florida. All five nursing homes held a "standard" rating from the Department of Health and Rehabilitative Services, Office of Licensure and Certification, Tallahassee, Florida (Annual report, 1988). A standard rating is defined as meeting the minimum standards for patient care as set by HRS.

Aides from all three work shifts (day, 7 a.m. to 3 p.m.; evening, 3 p.m. to 11 p.m.; and night, 11 p.m. to 7

a.m.) were included. Both males and females were included because the study was concerned with all persons who provide direct nursing and personal care to nursing home residents in the designated capacity of nursing aide, nursing assistant, nurse's aide, or orderly. Participation in the study was voluntary.

Procedures

The researcher made personal visits to nursing home administrators and directors of nursing (DONs) to explain the study and to ask permission to conduct it in the facility and during the aides' work-day. According to Dana (1982) and Lindzey (1961), the personal warmth of the person conducting testing directly affects the degree of rapport established with subjects participating in the study. In turn, the degree of rapport established affects the degree of responsiveness and openness of subjects in their test responses. In three nursing homes the researcher was well known to staff from inservice training seminars held by the researcher on the psychosocial needs of nursing home residents. In the other two facilities participating in the study, the researcher held similar inservice training seminars before testing was conducted in order to establish rapport with the aides and to create in all five nursing homes, as nearly as possible, comparable conditions for testing.

Dates and times for gathering data were set by the nursing home administrators and directors of nursing (DONs) to avoid conflicts with inspections from regulatory agencies or other facility-wide activities. Mid-week days (Tuesdays, Wednesdays, Thursdays) were selected to avoid time pressures on aides as they resumed their week-day schedule on Mondays or were involved in extra preparations on Fridays for the week-end. DONs made the decision relative to time and number of aides who could be released for testing from their duties and still cover patient care needs. Two DONs chose to have the aides come in small groups and to use nursing staff to cover for them. Three DONs chose to have aides come individually when they could catch up on their work and be away from the floor with other aides to cover for them. Since all instruments for gathering data could be administered individually or in groups, either arrangement was satisfactory. Hours for testing were from 10 a.m. to 9 p.m. for the day and evening shifts; from midnight to 4 a.m. for the night shift. In each nursing home a quiet area was provided for conducting the tests. The researcher conducted all testing procedures.

When subjects came for testing they were given an envelope which contained the two assessment instruments and the questionnaire used in the study. They were asked not to put their name on the envelope nor on any of the pages.

The researcher explained that this arrangement gave them the opportunity to respond any way they chose and no one would know which answers were theirs. They were assured that no one who worked at the nursing home would see any of the answers. Aides were also told that if they began filling in their responses and did not want to continue, they could stop at any time.

After aides opened the envelopes the researcher read to them the instructions for taking the tests and answered any questions about the forms or procedures. A few aides finished testing within 45 minutes, but the majority took an hour to an hour and 15 minutes to complete the three forms. As subjects completed the three forms they were asked to replace them in the envelope and return them to the researcher.

The general attitude of aides toward participating in the study appeared to be positive because they felt someone was interested in their feelings. One aide responded to the Rotter Incomplete Sentences Blank sentence stem, I like "being a part of this survey and hope it will help nursing aides." It was not easy for aides to take an hour or more out of their busy schedules to participate; however 88.6% of the aides working on the day of testing volunteered to be a part of the study. The administrative and supervisory staff gave support to the study by their willingness to add to their work load, either to cover patient care themselves

or to adjust aide duties so that a large number of aides could participate.

Instruments

Two standardized instruments and a questionnaire were used to collect data: (a) the Rotter Incomplete Sentences Blank (Adult Form); (b) the Spielberger Trait-Anxiety scale (Form Y-2); and (c) a structured questionnaire developed by the researcher.

Rotter Incomplete Sentences Blank--Adult Form

The Rotter Incomplete Sentences Blank (RISB) is a projective personality assessment instrument. It is composed of 40 sentence stems to be completed by the subject. According to Rotter (1954, p.305), the responses give information relative to personality "content"--feelings, attitudes, and specific reactions to people and things.

Positive (healthy) responses are classified into three groups depending on the degree of good adjustment expressed and are given numerical weights of 0, 1, and 2; with a value of 0 indicating the best adjustment. Neutral responses are those which are generally simply descriptive and are neither positive nor express conflict. Neutral responses are scored 3. Conflict responses indicate an unhealthy or maladjusted frame of mind, according to Rotter and Rafferty (1950) and are given values of 4, 5, 6 according to the degree of maladjustment expressed. The

numerical weight of each score is totaled to obtain an over-all score for each subject, with low scores representing better personal adjustment and higher scores indicating greater personal maladjustment.

Scoring the RISB is relatively objective and standardized because explicit instructions and examples are given in the manual as to what constitutes positive, neutral, or conflict responses. To prevent researcher bias, a clinical psychologist and a school psychologist with Ph.D. degrees scored the responses of the RISB in this research under the direction of a university professor/clinician experienced in administering and scoring the RISB. Inter-rater reliability for the two psychologists was .87, using the Pearson product moment coefficient of correlation.

Because low levels of education and minority status are common among nursing aides, two requisites for instruments used in this study were that they be easily read and comprehended and as culture fair as possible. The RISB meets these requirements. The sentence stems contain simple words easily understood by those with limited education. The stem words are based on relationships (e.g., A mother . . .) and emotions (e.g., My greatest fear . . .) which tend to be culture free. In addition, the freedom of response used by the RISB increases its validity as a culture fair measurement. Anastasi (1961) noted that

personality projection completion tests (such as an the RISB) allow contents of statements to be analyzed as well as provide a total adjustment score. Content analysis of responses made by nursing aides concerning their perceptions, feelings, and attitudes toward the nursing home work environment was of interest in this study. It was not necessary, however, for the responses of aides to be related to their work in order to be scored on the RISB; therefore, the RISB could measure personality adjustment among nursing aides regardless of how long an aide had been employed in nursing homes.

Another of the advantages of the RISB for use with aides is that it is untimed, allowing for a more relaxed attitude on the part of the subject, especially for persons who may be anxious about test-taking. Because the RISB may be taken individually or in groups, it fitted the more flexible schedule needed for research with aides during their nursing home work-day.

The RISB was standardized on 299 college freshmen at Ohio State University (Rotter & Rafferty, 1950). The adult form of the test is only slightly modified from the college form. Correlated split-half reliability for the test is reported in the manual as .84 for males and .83 for females; inter-scorer reliability as .91 for males and .96 for females. Walker and Linden (1967) evaluated the interscorer reliability of 20 RISB scorers from diverse

professional orientations and levels of training and experience in psychology. The researchers concluded that all raters were able to classify subjects as normal, neurotic, or psychotic with an accuracy better than chance.

Fulkerson and Gettys (1965) conducted a blind study of 39 hospital mental patients and a college student sample considered to be well adjusted. The researchers found the maladjustment score from the RISB to differentiate between the two groups. One of the limitations of the RISB is that responses may be confounded with social desirability. Janda and Galbraith (1973) contended that social desirability of response is also a component of other measurements of adjustment and that it does not challenge the predictive validity of the RISB. Anastasi (1961) postulated that projective techniques for personality testing are somewhat disguised in purpose, thereby reducing chances that subjects can deliberately create a desired impression.

Trait-Anxiety Scale (Form Y-2)

The State-Trait Anxiety Inventory (STAI) developed by Charles D. Spielberger (1983) is a 40-item self-report scale which uses a Likert-type response format. Twenty items on the scale evaluate state-anxiety; the other 20 items measure trait-anxiety. Spielberger made a distinction between trait-anxiety and state-anxiety. He defined trait-anxiety as a relatively enduring personality

trait which largely determines the reaction pattern of an individual to stressful or dangerous situations.

Spielberger (1983) theorized that the "stronger the anxiety trait, the more probable that the individual will experience more intense elevations in state-anxiety" (p. 1). State-anxiety is defined by Spielberger as being that anxiety which is transitory. It may occur at any time and varies in intensity and duration according to an individual's perception of the threatening nature of the stimuli.

According to Spielberger, higher correlations exist between trait-anxiety and state-anxiety in social situations, with correlations being typically higher in situations involving interpersonal relationships which threaten self-esteem and where personal adequacy is evaluated. Spielberger theorized that individuals with high levels of anxiety-proneness (T-Anxiety) also experience more frequent and intense elevations of state-anxiety (S-Anxiety). Thus, according to this theory, since nursing aides work under circumstances which both threaten their self-esteem and where personal adequacy is continually monitored during the work day, high scores on the T-Anxiety scale would indicate that an aide also experiences high levels of job-related apprehension, worry, and tension (S-Anxiety). Because S-Anxiety scores would

approximate T-Anxiety scores under these conditions, only the T-Anxiety scale was used in this research.

According to the manual, a revision of the STAI was begun in 1979, among other reasons, to increase its validity and reliability for use with persons from lower socioeconomic groups and those less educated--both important considerations for this study. The STAI (Form-Y) was normed on working adults, college students, high school students, and military recruits. The norms on working adults were based on 1,378 males and 451 females employed by the Federal Aviation Administration with ranges in age, educational level, and job responsibility.

The reliability coefficient for working adults was .91 for males and females on the T-Anxiety scale. The overall median alpha coefficient of the scale was reported as .90. Construct validity of the T-Anxiety scale for discriminating between psychiatric and normal subjects was established by comparing mean scores of 461 neuropsychiatric patients with 5,081 normal subjects. Trait-anxiety scores were substantially higher for all but one of the neuropsychiatric subjects than for the normal subjects. Concurrent validity for Form-X (which is highly correlated with Form-Y, according to the manual) was established by comparisons with other measures of anxiety--the IPAT Anxiety Scale, Manifest Anxiety Scale, and Affect

Adjective Check List. Correlations with these measures ranged from .73 to .85.

The 20 items of the T-Anxiety scale used in this study have a weighted score from 1 to 4. For anxiety-present items a rating of 4 indicates high anxiety. Anxiety-absent items are scored in reverse, with 1 representing the lowest amount of anxiety. Scores can range from a minimum of 20 to a maximum of 80. The scale can be administered individually or in groups. According to the manual, the test requires approximately 10 minutes to complete. For most aides it took longer. Because scoring was based on a standardized key, responses were scored by the researcher.

Dreger (1978) considered the STAI to be an excellent standardized measure of anxiety. Katkin (1978) cited the reasonably large number of subjects in each category of the normative sample, the concise and explicit instructions of the test manual for administering and scoring the test, and the well-grounded psychological theory on which the test is based as some of the strengths of the STAI as a measure of anxiety.

Questionnaire

A third component of the data was a questionnaire developed by the researcher (Appendix A). The questions were brief and simply stated for purposes of optimum reading comprehension. Answers were designed for ease of response. Questions 1 through 5 were

1. How long have you worked in this nursing home?
2. How long have you worked in other nursing homes?
3. In how many other nursing homes have you worked?
4. Do you like your job?
5. Do you like older people?

Questions 6 and 7 dealt with age and gender.

Research Questions

The research questions posed in this study were

1. What is the mean personality adjustment score of nursing aides currently employed in selected nursing homes as measured by the Rotter Incomplete Sentences Blank?
2. What is the mean anxiety score of nursing aides currently employed in selected nursing homes as measured by the Trait-Anxiety scale (Form Y-2) of the State-Trait Anxiety Inventory (Form-Y)?.
3. Is there a relationship between personality adjustment score and anxiety score among these nursing aides?
4. Are the personality adjustment scores of these nursing aides a function of their age, length of time employed in nursing homes, and/or the number of nursing homes in which they have worked?
5. Are the personality adjustment scores of these nursing aides a function of the nursing home in which they work, the shift they work, shift-by-nursing-home

interaction, their age, age-by-shift interaction, whether they like the job, and/or their gender?

6. Are the anxiety scores of these nursing aides a function of their age, length of time employed in nursing homes, and/or the number of nursing homes in which they have worked?

7. Are the anxiety scores of these nursing aides a function of the nursing home in which they work, the shift they work, shift-by-nursing-home interaction, their age, age-by-shift interaction, whether they like the job, and/or their gender?

Data Analyses

Data based on scores obtained from the assessment of personality adjustment and anxiety level (questions 1 and 2) were analyzed using descriptive statistics. The direction and strength of the relationship between personality adjustment scores and anxiety scores, posed by question 3, were determined by the Pearson product moment coefficient of correlation. The relationship between both personality adjustment scores and anxiety scores and other variables in questions 4, 5, 6, and 7 was determined by multiple regression. The direction and strength of the relationship between these variables were determined by Pearson coefficients of correlation.

Limitations

The use of volunteers as subjects for this study poses limitations as to the generalizability of results. Economic conditions vary across the country, different minority groups cluster in certain areas, and urban and rural areas draw from different socioeconomic groups. Each of these contingencies impacts on who self-selects themselves to apply for work in nursing homes. In addition, aides with little formal education and those uncomfortable with test-taking procedures may not have participated in numbers proportionate to their representation on the nursing home staff. All data were obtained by self-report, which relied on the subject's memory, particularly as to the length of time worked in the current job and in previous nursing home jobs. This made the information gathered subject to recall bias. In order to give aides the utmost feeling of confidentiality, permission to examine their personnel records was not requested. Another limitation of a study involving the attitudes of nursing aides toward working with older persons is a possible tendency of aides to give a socially desirable response rather than to state negative feelings and perceptions.

CHAPTER IV RESULTS

The purpose of this study was to investigate personality adjustment and level of anxiety among nursing aides currently employed in selected nursing homes and to relate these factors to demographic and work-related variables.

Personality adjustment was determined by scores on the Rotter Incomplete Sentences Blank. Anxiety level was measured by scores on the Spielberger Trait-Anxiety scale. Demographic variables for the aides included number of nursing homes where employed, duration of current employment, total length of employment in previous nursing aide positions, and whether the aide liked or disliked the job. All demographic data were obtained by self-report of the subjects.

Description of Sample

Participants in the study were 124 nursing assistants from five nursing homes in North Florida. Aides from all three work shifts were included: 51 (41.1%) worked the day shift (7 a.m. to 3 p.m.), 42 (33.9%) worked the evening

shift (3 p.m. to 11 p.m.), and 31 (25%) worked the night shift (11 p.m. to 7 a.m.).

Participation in the study was voluntary and 88.6% of the aides who were working in the selected nursing homes at the time of testing participated. Information on the total number of aides in each of the three work periods on the days of testing was provided by directors of nursing, assistant directors of nursing, or other staff members with access to personnel information.

Summary of Demographic Data

Of the 124 subjects in the study, 91.9% were female and 8.1% were male. Because both females and males fill comparable roles in direct patient care, both sexes were included in the study. Ages of aides who participated ranged from 19 to 61 years, with a mean age of 33; a median age of 31. (Because there is some skewness in the distributions of age, length of employment, and number of nursing homes in which aides have worked, the median may be more appropriate for characterizing central tendency.)

Duration of employment in the nursing home in which the aide was currently employed ranged from one week (for 4 aides) to 16 years (for 1 aide). Forty aides had worked only in the nursing home in which they were currently employed. Among the 124 aides in the study, 63.7% had worked 1 year or less in the current job (51.6% had worked 6 months or less), 20.2% had worked from 1 to 3 years,

11.3% from 3 to 6 years, and 4.8% had worked over 6 years. The mean number of years in the current job was 1.6; and the median length of time in the current job was .5 years.

The total length of employment as an aide (the length of current employment plus the length of any prior employment) ranged from 1 week to 25.75 years; 29.8% of the participants had worked 1 year or less; 27.4%, 1 to 3 years; 18.6%, 3 to 6 years; and 24.2% had worked over 6 years. The mean total length of nursing home employment as an aide was 3.9 years; and the median was 2.2 years.

Of 122 subjects who reported the total number of nursing homes in which they had worked, 32.8% had worked in only one nursing home (where they were currently employed); 27% had worked in a total of two nursing homes; 18%, in three; 15.6%, in four; 3.3%, in five; 2.5%, in six; and .8% had worked in a total of eight nursing homes. The mean number of nursing homes in which aides had been employed was 2.4 nursing homes; the median number was 2.

Results for Major Research Questions

In this section results for the data analyses are reported in sequential order for the seven research questions addressed in the study. For each question descriptive statistics for the relevant data are presented followed by results of the inferential statistical procedures used to address that question.

1. What is the mean personality adjustment score of nursing aides currently employed in selected nursing homes as measured by the Rotter Incomplete Sentences Blank?

Scores on the Rotter Incomplete Sentences Blank (RISB) (Rotter & Rafferty, 1950) for the 120 subjects in this study ranged from 97 to 156 with a mean of 125.94 (S.D.=11.28). Normative RISB data for 299 college freshmen indicated a mean of 127.5 (S.D.=14.3) (see Table 4-1). Scores for nursing aides were less variable than for the normative sample because, in general, nursing aides are a more homogenous group than a class of college freshmen. Using a t -test for contrasting sample means, the mean personality adjustment score for the nursing aide sample was not significantly different from the college freshmen group on which the RISB norms are based ($t = 1.18$, infinite df, $p > .05$).

Table 4-1

Means and Standard Deviation Scores for RISB and T-Anxiety

	<u>Sample Group</u>			<u>Norm Group</u>		
	N	Mean	S.D.	N	Mean	S.D.
RISB	120	125.94	11.28	299	127.5	14.3
T-Anxiety	124	40.56	9.21	1,838	34.86	9.20

Four subjects in this study did not complete the number of responses necessary for scoring on the RISB. Fifty-nine aides (49.2%) scored between 97 and 125 points; 37 aides (30.8%) scored between 126 and 134; and 24 aides (20%) scored 135 to 156 points.

According to the RISB manual, a cutting score of 135 provides an efficient separation of adjusted and maladjusted persons and correctly identifies 75% to 80% of those considered to be maladjusted. By this criterion, 20% of the aides in the group tested could be classified as maladjusted; among the norm group of college freshmen, 31% of the group could be classified as maladjusted.

2. What is the mean anxiety score of nursing aides currently employed in selected nursing homes as measured by the Trait-Anxiety scale (Form Y-2) of the State-Trait Anxiety Inventory (STAI Form-Y)?

Scores on the T-Anxiety scale can vary from a minimum of 20 to a maximum of 80, according to the STAI manual (Spielberger, 1983). Scores for the 124 subjects in this study ranged from a minimum of 20 to a maximum of 60. The mean score for the group was 40.56 (S.D.= 9.22). This mean was contrasted with a mean of 34.86 (S.D.= 9.20) as the norm established for working adults (Spielberger, 1983) (see Table 4-1). The mean score for the nursing aide sample was 5.72 points higher than the norm for working adults. Using a t-test for contrasting sample means, the

mean anxiety level among nursing aides was found to be significantly higher than the mean for the group of working adults on which STAI norms are based ($t = 7.8$, infinite df , $p < .001$).

3. Is there a relationship between personality adjustment score and anxiety score among these nursing aides?

Bivariate correlations among the Rotter Incomplete Sentences Blank, the T-Anxiety scale, and the continuous demographic variables are shown in Table 4-2.

Table 4-2

Correlation of RISB and T-Anxiety Scores with Age, Experience, and Number of Nursing Homes

	RISB	T-Anxiety	Age	Experience	Number of Nursing Homes
RISB	1.00	0.40*	-0.12	-0.09	0.01
T-Anxiety		1.00	-0.16	-0.02	-0.02
Age			1.00	0.41*	0.06
Experience				1.00	0.47*
Number of Nursing Homes					1.00

* $p < .001$

Nursing aide scores on the Rotter Incomplete Sentences Blank and the Trait-Anxiety scale had a significant Pearson product moment correlation coefficient of $r = .40$, $p < .001$ (see Table 4-2). Thus aides with higher scores on the RISB tended to have higher scores on the T-Anxiety scale.

4. Is the personality adjustment score of these nursing aides a function of their age, length of time employed in nursing homes, and/or the number of nursing homes in which they have worked?

A multiple regression analysis indicated no significant relationship between RISB scores and the weighted linear combination of age, length of time employed in nursing homes, and number of nursing homes in which aides have worked. Table 4-3 contains results of the significance test for the linear model applied to test the hypothesis of no relationship between RISB scores and the variables of age and employment history.

Table 4-4 displays the F -ratios for testing the significance of the contribution of each independent variable in the model. As shown in Table 4-4, none of the three variables contributed significantly to variance in the RISB scores of the nursing aides. These findings are consistent with the zero-order correlations shown in Table 4-2.

Table 4-3

Summary Table for the Linear Model of RISB Scores Regressed on Age, Nursing Home Work Experience, and Number of Nursing Homes

Source	SS	df	MS	R ²	F	p
Model	246.04	3	82.01	0.02	0.63	0.60
Error	14696.73	113	130.06			
Total	14942.77	116				

Table 4-4

Sums of Squares Table for the Effects of Age, Nursing Home Work Experience, and Number of Nursing Homes on RISB Scores

Source	SS	df	MS	F	p
Age	132.44	1	132.44	1.02	0.32
Experience	22.24	1	22.24	0.17	0.68
Number of Nursing Homes	13.43	1	13.43	0.10	0.75
Error	14696.73	113	130.06		

5. Is the personality adjustment score of these nursing aides a function of the nursing home in which they work, the shift they work, shift-by-nursing-home interaction, their age, age-by-shift interaction, whether they like the job, and/or their gender?

An analysis using the linear model of RISB score regressed on nursing home, shift, shift-by-nursing home interaction, age, age-by-shift interaction, liking of job, and gender revealed no significant relationship between the RISB scores and the set of seven independent variables and interactions (See Table 4-5). Altogether the predictor variables and their interactions accounted for only 17% of the variability in RISB scores. The sums-of-squares table for the individual effects in the model are shown in Table 4-6. The RISB score was significantly related to the aide's attitude toward liking the job ($F = 4.50$, 1 and 99 df, $p < .05$), despite the fact that the overall F -test for the model was not significant. This anomalous finding may indicate that too many variables were included in the original model, and results must be interpreted with caution.

Table 4-5

Summary Table for the Linear Model of RISB Scores Regressed on Nursing Home, Shift, Shift * Nursing Home, Age, Age * Shift, Like Job, and Gender

Source	SS	df	MS	R^2	F	p
Model	2620.06	19	137.90	0.17	1.10	0.36
Error	12387.81	99	125.13			
Total	15007.87	118				

Table 4-6

Sums of Squares Table for the Effects of Nursing Home, Shift, Shift * Nursing Home, Age, Age * Shift, Like Job, and Gender on RISB Scores

Source	SS	df	MS	F	p
Nursing Home	270.36	4	67.59	0.54	0.71
Shift	152.48	2	76.24	0.61	0.55
Shift * Home Interaction	742.48	8	92.81	0.74	0.65
Age	107.08	1	107.08	0.86	0.36
Age * Shift	207.63	2	103.82	0.83	0.44
Like Job	563.38	1	563.38	4.50	0.04*
Gender	7.55	1	7.55	0.06	0.81
Error	12387.81	99	125.13		

* $p < .05$

Because neither shift-by-nursing home interaction nor age-by-shift interaction were significant, they were removed from the model and a further regression analysis was performed using a reduced model with nursing home, shift, age, liking job, and gender as variables. Whether the aide liked or disliked the job was again the only significant variable in this analysis ($F = 5.01$, 1 and 109 df, $p < .05$) (see Tables 4-7 and 4-8).

Table 4-7

Summary Table for the Linear Model of RISB Scores Regressed on Nursing Home, Shift, Age, Like Job, and Gender

Source	SS	df	MS	R ²	F	p
Model	1623.42	9	180.38	0.11	1.47	0.17
Error	13384.45	109	122.79			
Total	15007.87	118				

Table 4-8

Sums of Squares Table for Effects of Nursing Home, Shift, Age, Like Job, and Gender on T-Anxiety Scores

Source	SS	df	MS	F	p
Nursing Home	472.56	4	118.14	0.96	0.43
Shift	19.18	2	9.59	0.08	0.92
Age	160.63	1	160.63	1.31	0.26
Like Job	615.55	1	615.55	5.01	0.03*
Gender	8.31	1	8.31	0.07	0.80
Error	13384.45	109	122.79		

* $p < .05$

6. Is the T-Anxiety score of these nursing aides a function of their age, length of time employed in nursing

homes, and/or the number of nursing homes in which they have worked?

A multiple regression analysis indicated no significant relationship between T-Anxiety scores and the predictor variables of age, length of time employed in nursing homes and the number of nursing homes in which aides have worked (see Tables 4-9 and 4-10). Again, this finding is consistent with the zero-correlations of the three predictor variables with T-Anxiety scores shown in Table 4-2.

Table 4-9

Summary Table for the Linear Model of T-Anxiety Scores Regressed on Age, Length of Nursing Home Employment, and Number of Nursing Homes

Source	SS	df	MS	R ²	F	p
Model	323.33	3	107.78	0.03	1.26	0.29
Error	10027.10	117	85.70			
Total	10350.43	120				

Table 4-10

Sums of Squares Table for the Effects of Age, Nursing Home Work Experience, and Number of Nursing Homes on T-Anxiety Scores

Source	SS	df	MS	F	p
Age	320.43	1	320.43	3.74	0.06
Experience	65.38	1	65.38	0.76	0.38
Number of Nursing Homes	21.69	1	21.69	0.25	0.62
Error	10027.10	117	85.70		

7. Is the T-Anxiety score of these nursing aides a function of the nursing home in which they work, the shift they work, shift-by-nursing-home interaction, their age, age-by-shift interaction, whether they like the job, and/or their gender?

An analysis using the linear model of T-Anxiety score regressed on nursing home, shift, shift-by-nursing home interaction, age, age-by-shift interaction, liking job, and gender revealed that a significant portion of variability in T-Anxiety scores is explained by the other variables in the model (see Table 4-11). The sums of squares table for the individual effects in the model indicated a significant relationship between T-Anxiety scores and nursing home ($F=2.71$, 4 and 103 df, $p < .05$) No significant relationship

was found between T-Anxiety scores and shift, shift-by-nursing home interaction, age, age-by-shift interaction, like job, and gender (see Table 4-12).

Table 4-11

Summary Table for the Linear Model of T-Anxiety Scores Regressed on Nursing Home, Shift, Shift * Nursing Home, Age, Age * Shift, Like Job, and Gender

Source	SS	df	MS	R ²	F	p
Model	2683.17	19	141.22	0.26	1.88	0.02*
Error	7748.68	103	75.23			
Total	10431.85	122				

* $p < .05$

Because no significant relationship was indicated by shift-by-nursing home interaction or age-by-shift interaction, these variables were removed and a further regression analysis was performed using only nursing home, shift, age, like job, and gender as variables (see Table 4-13).

Table 4-12

Sums of Squares Table for the Effects of Nursing Home, Shift, Shift * Nursing Home, Age, Age * Shift, Like Job and Gender on T-Anxiety

Source	SS	df	MS	F	p
Nursing Home	814.31	4	203.58	2.71	0.03*
Shift	376.90	2	188.45	2.51	0.09
Shift * Home Interaction	544.89	8	68.11	0.91	0.52
Age	214.18	1	214.18	2.85	0.09
Age * Shift	183.66	2	91.83	1.22	0.30
Like Job	21.10	1	21.10	0.28	0.60
Gender	15.79	1	15.79	0.21	0.65
Error	7748.68	103	75.23		

Table 4-13

Summary Table for the Linear Model of T-Anxiety Scores Regressed on Nursing Home, Shift, Age, Like Job, and Gender

Source	SS	df	MS	R ²	F	p
Model	1943.24	9	215.92	0.19	2.87	0.004*
Error	8488.61	113	75.12			
Total	10431.85	122				

* $p < .01$

Table 4-14

Sums of Squares Table for the Effects of Nursing Home, Shift, Age, Like Job, and Gender on T-Anxiety Scores

Source	SS	df	MS	F	p
Nursing Home	861.73	4	215.43	2.87	0.03**
Shift	749.25	2	374.62	4.99	0.01*
Age	336.29	1	336.29	4.48	0.04**
Like Job	43.07	1	43.07	0.57	0.45
Gender	2.28	1	2.28	0.03	0.86
Error	8488.61	113	75.12		

* $p < .01$, ** $p < .05$

The F -test indicated a significant relationship between T-Anxiety scores and nursing home ($F = 2.87$, 4 and 113 df, $p < .05$); shift ($F = 4.99$, 2 and 113 df, $p < .01$); and age ($F = 4.48$, 1 and 113 df, $p < .05$). A Tukey test of pairwise comparisons showed a significant difference in mean anxiety scores between nursing homes 4 and 5 in the study. Tukey comparisons indicated no significant differences in anxiety scores among all other possible pairings of the five nursing homes. Results of the Tukey comparison of anxiety scores by shift showed anxiety scores for the evening shift (3 p.m. to 11 p.m.) were significantly different from anxiety scores for the day (7 a.m. to 3 p.m.) and the night shift (11 p.m. to 7 a.m.).

Aides on the day shift had a mean anxiety score of 39.16; aides on the evening shift, 43.17; on the night shift, 38.52. It is interesting to note that age had a significant effect on anxiety, when the effect of other variables were controlled, even though the zero-order correlation between the two variables, presented in Table 4-2, was not significant.

Summary of RISB Responses

One of the primary reasons for the choice of the Rotter Incomplete Sentences Blank (RISB) as a measure of personality adjustment was that it offered an opportunity for aides to express feelings, attitudes, and perceptions without the limitations of a forced choice format. The study offered anonymity to the subject, which enhanced freedom of response.

Aides were instructed that they could complete the 40 RISB sentence stems in any way they chose. No suggestion was made that the feelings expressed in responses be work-related. Nevertheless, many of the sentence completions did indicate how nursing aides perceived their work and interpersonal relationships within the nursing home. From these work-related responses a number of common themes emerged. The quotes used in this summary of some of these themes were chosen by the researcher because they were either representative of the responses pertaining to the

theme or because they showed the range and/or the intensity of the feelings, attitudes, and perceptions expressed.

Of the 124 subjects in the study, 120 completed the necessary number of sentence stems to be scored on the RISB; therefore, statistics summarizing responses to the RISB are based on 120 scores. In analyzing the responses, sentence stem words are underlined and nursing aide responses are enclosed in quotes.

Caregiver Role

The majority of aides (59.2%) expressed a sense of fulfillment about working with people and particularly old people: I am best "when I can come to work and be with someone who needs my help"; The happiest time "is helping others"; I like "my job because I like working with old people and feel good that I have helped someone in need"; I like "being responsible and caring for other people"; I feel "best when I'm helping older people."

Although the majority of aides expressed a desire to help others, 44 aides (36.7%) stated a need to feel more confident and competent in their work. These statements ranged from I want to know "how to get along better with people" to I want to know "more about how to keep patients smiling." Concerns of aides about their job performance included: I need "to know more about being an aide"; My greatest fear "not noing if I am doing my job right"; I

regret "not knowing more about my work"; I need "to know more about how to take care of my patients."

A sensitivity to the psychological implications of being old and living in a nursing home was expressed by 14.2% of the aides: I want to know "how they feel being in a nursing home"; I want to know "how they sometimes feel knowing that they will never return home again"; At bedtime "I lie awake wondering what it would be like to be old"; When I was a child "I was abused so I know how it feels to be hurt and neglected."

Some of the responses indicated that thoughts about patients are an ever-present part of the lives of aides. Of 114 aides who responded to the stem words, At bedtime, 37.7% noted that they pray or otherwise stated a religious orientation. Many aides made specific reference to praying for patients or to thinking of them while at home: At bedtime "I pray for all the residents and others"; "I pray that some of the pain some of them feel could just go away"; "I pray about my patients because I love them"; "I lay awake often and think about my patients." At home "I think about all my patients wondering what going on with them if they are died"; I can't "express how I feel when I'm working with these patients because when I go home they are always on my mind."

Aide/Family Relationships

Responses to RISB stem words indicated that aides have close ties to their own parents and to their children. The RISB uses the impersonal stem words, A mother, which elicited positive responses from 88.4% of the aides: A mother "is someone who loves you and you love them"; "is the best thing next to God"; "is the most wonderful person in the world." Many responses personalized the aide's relationship with her own mother: A mother "is my best friend", "a very special person to me", "my life next to my kids." Only one response (.8%) was negative; 5.8% were neutral; and 5% omitted a response.

In responding to the cue words, My father, 55.8% of the aides made positive statements, such as terming him "my best friend", "most admired man I know", "proud and honest", "very special person," "kindest person I know." Only 12.5% of the comments were negative such as "I hate," "needs to know what love is," "abused me when I was a child," "not a father--left me when I was born." Twenty aides (16.7%) recorded that their father was dead; 6.7% made other neutral comments; 8.3% gave no response.

Neither "children" nor "family" were stem words in the RISB; however, 56.5% of the aides completed at least one and sometimes more sentences with positive statements about their family and/or their children: The best "thing in life are my four children"; I "love being a mother"; I

"love my parents"; The happiest time "is being with my family"; When I was a child "I was hungry but loved."

Twelve aides (10%) used the similitude of family relationships to describe their relationship to patients: A mother "my feelings to most of these old lady is like my mother"; I can't "help feel close to some of my patients almost like they're my grandparents"; I feel "that in helping the residents I am helping my parents all over"; A mother "is like some of us are to the patients--careing loveing."

Patient Families

In contrast to the positive feelings the majority of aides expressed toward their relationships with their own families, 10 aides implied or expressed a criticism of patient families: I can't "understand why so many geriatric patient aren't home with family"; I "would not want my mother in a nursing home"; I can't "understand why some people put their parents in a nursing home when they could keep them home with family"; What pains me "is when there family leave them and never come back to see them."

Tension

From the response of aides to the sentence stem, My nerves, it was apparent that even among those aides who liked their job (91.9%) and those who stated that they derived satisfaction from working with people (59.2%), working in a nursing home is a stressful and anxiety-

inducing occupation. Of the 120 aides who completed the RISB, 31.7% stated that their nerves were "o.k." to "very good"; 60% responded with various degrees of negative comments about the state of their nerves; 8.3% made neutral statements or gave no response. One aide commented, My nerves "has to be good to work in a nursing home." Among the negative comments directly associated with the work environment were: I "am very stressful because my employment is so hard all the time"; My nerves "are so bad I don't know how I work with these peoples"; My mind "is getting very bad working with the elderly"; Sometimes "when things get tough I want to scream"; My nerves "are awfully frazzled when I leave work"; My nerves "become shot after a long day feeling I can't cope."

Responses from two sentence stems often give more insight than single responses. An aide who responded My nerves "are very bad when upset" also stated, Sometimes "I can get very mean." Another whose nerves "are always on edge" also stated, I suffer "from an uncontrollable temper."

Responses to sentence stems such as What annoys me and What pains me elicited from 18 aides (15%) comments about patient behavior, common especially among mentally or emotionally impaired patients: "when one of the patients starts shouting"; "when I have to repeat myself"; "when people ask questions over and over"; "when someone can't

shut up." One aide commented, Sometimes "I sometimes enjoy working with old people but they get to me."

Physical Fatigue

Twenty-three aides (19.2%) noted the fatigue they experience. Ten aides said they had difficulty getting to sleep at night. Some of these responses were: At bedtime "I am too tired to sleep"; "It takes a long time to get rid of the tension"; "My bones are so tired." Typical of other responses concerning fatigue were: Sometimes "the work load is so very heavy"; I "am very tired when I get off work"; I need "a vacation I am very tired." Eight aides stated they suffer from headaches: I suffer "from frequent headaches because of this job."

Emotional Fatigue

In addition to the physical fatigue, 45 aides (37.5%) commented on something akin to an emotional fatigue, e.g., 20 of these aides referred to feeling lonely at times; others indicated they experienced feelings of depression, sadness, having failed in life: I feel "trapped sometimes wish I could make something better of myself"; Sometimes "I cry because I am so depressed about life"; I feel "so lonely sometimes"; I feel "sometimes like no one cares"; I feel "like sometimes life is passing me by." Two aides directly related a feeling of sadness to the job: I regret "seeing these poor people in here makes me sad", Sometimes "I feel sorrow for the elderly".

Twenty-three aides (19.2%) completed the sentence stems What pains me and I suffer with such statements as What pains me "is when so many are suffering"; What pains me "is when I can't help someone"; I suffer "when I see elders crying."

One of the work-related anxieties mentioned by 17 aides (14.2%) was what they perceived to be mistreatment of patients: My nerves "get on edge to see people mistreated"; I can't "stand to see any of the old people treated badly, they do you know"; Sometimes "I get very angry when a patient is mistreated."

Death

Although death was not a stem word, 36.7% of the aides commented on their attitudes toward death or disease in response to other sentence stems. Some of the responses related to the aide's feeling about the death of patients were: Sometimes "you can take it sometimes you can't"; I want to know "how come my special patients has to die. I love them all, but you have a special one"; My greatest fear "is being too close to a patient and they die because I know it will hurt"; I suffer "hard when my residents suffer or one dies." Three aides said their greatest fear was finding one of their patients dead.

Fear of the death of a loved one was mentioned by 10 aides; 12 aides stated a generalized fear of their own death. Two aides expressed a fear of dying from working in

a nursing home. Related to attitudes toward death were comments by two aides that their greatest fear was of "diseases"; one aide expressed as her greatest fear "aids and nursing home diseases."

Getting Old

Seventeen aides (14.2%) saw their own aging in fearful terms, perhaps experienced vicariously through their nursing home patients. In general, their responses connoted a negative attitude toward being institutionalized. Typical of age-related responses to My greatest worry or My greatest fear were: "someday I may be old and have to be in a nursing home"; "being like some of these people [and] being alone when I get old"; "do I have to come to a nursing home"; "having to grow old and have someone care for me"; "what will happen to me when I get older"; I suffer "thoughts of being dependent on others." One aide said her greatest worry was "getting old and useless." Another aide pondered about aging: Sometimes "I wonder what I will be like at 80."

This Place

Aides' responses to the stem words This place were almost evenly divided between negative (46.7%) and positive (45%). Neutral, omitted, or unrelated responses totaled 8.3%. Positive responses included "love it"; "nice place to work at and I enjoy it a lot"; "has been good therapy for me." Negative responses included "makes me feel like I

haven't accomplished anything"; "depress me"; "could be a better place to work." One aide summed up the dichotomy of emotions about working in a nursing home, which several aides expressed in a variety of ways--This place "I hate I love the peoples [patients] in it."

Intra-staff Relationships

A total of 82 comments were made by 68 aides about paraprofessional (aide)/professional nursing staff relationships, the lack of teamwork among nursing staff, and/or the friction caused by working short of help.

Negative attitudes expressed by 56.7% of the aides concerning intra-staff relationships are in contrast to the positive attitudes expressed by 59.2% of the aides in the study relative to their sense of fulfillment as a caregiver to others. Comments on the aide/nurse relationship focused on the aide's perception of a condescending attitude on the part of the professional nursing staff toward nursing aides, a lack of teamwork with aides on the part of nurses in direct patient care, and a lack of recognition and appreciation on the part of management and the professional nursing staff for the difficult job of the nursing aide. Examples of the comments are: What annoys me "is nurses don't think we are people like theirselves they think they can talk to us like children"; I hate "nurses some time they forget we are people too"; What annoys me "is the attitude of some nurses toward us aides"; I regret "there

is no teamwork when the nurses won't help"; What annoys me "is when a light come on and a nurse think she is too good to answer"; I want to know "do nurses really appreciate NA"; I want to know "why NAs don't get the respect they deserve by the rest of the staff"; What annoys me "is when you do the best you can and get treated like dirt."

Twenty-six comments by aides related to a general lack of teamwork among the staff: This place "could be better if aides work harder and work together"; I suffer "when co-workers won't work together as a team"; I hate "when other people put their work off on me"; What pains me "is when you work so hard and no one want to help"; I regret "the misunderstanding people have on the job."

Attitudes toward what aides construed to be working short of help were expressed in 22 sentence completions: I hate "working short of help"; I can't "work right when we are understaffed"; I hate "all no calls and no shows"; What pains me "is when there is not enough staff to care for patients correctly."

Lack of Recognition

Thirty-one aides (25.8%) commented either on the lack of respect and recognition they feel they receive for doing their job or the pleasure they feel when their work is appreciated. Typical of these comments were: What pains me "is sometime you work so hard and have to tell yourself thank you"; What annoys me "is no respect or thanks for

doing my work"; What pains me "is when I am trying so hard and no one cares"; I regret "no one cares how NAs feel."

The happiest time "is when I help someone and they say thank you"; The best "is when a patient and family appreciate my work"; The happiest time "is when you are really helping someone and they appreciate it."

Pay

Although neither money nor pay were stem words in the RISB, seventy aides (58.3%) responded to stem words such as I need, I want to know, I wish in terms of their attitude toward their pay.

Many of the comments reflected the attitude of aides that pay was not commensurate with the work: I can't "really understand why NAs has the hardest job and work for less"; I want to know "why we do more work and don't get paid enough"; I hate "the money I'm making for the work"; I want to know "Why do aides do lots of work for little pay"; I can't "understand why our salary is so small for all this hard work." One aide summed up her feelings about work and pay, I wish "it was understood the hard work you do, the love and care you give, and the low pay you get."

Aides also stated the impact on themselves and their family of what they consider to be inadequate pay: The only trouble "is making it from one pay day to the next"; My greatest worry "never having enough money if something goes wrong"; I hate "when I can't give my

children the things they need"; I fail "my family by not having enough money"; What pains me "is to see my children doing without." Only one aide, 25 years old with three months total experience in nursing homes, stated satisfaction with the pay.

CHAPTER V SUMMARY AND CONCLUSIONS

Summary

The purpose of this research was to expand the limited information available to nursing home administrators, directors of nursing, researchers, and others concerning criteria for more effective selection, training, and retention of nursing aides. Results of the study could improve the nursing home work environment and enhance the quality of patient care. To accomplish this purpose, the investigator examined personality adjustment and levels of anxiety among nursing aides employed in selected nursing homes and related these factors to demographic and work-related variables.

Participants in the study were 124 nursing aides currently employed in five nursing homes in North Florida; 88.6% of the aides working at the time of testing volunteered for the study. Personality adjustment/maladjustment was determined by cumulative weighted scores on the Rotter Incomplete Sentences Blank (RISB). Two Ph.D. professional level psychologists evaluated the responses of aides to the RISB sentence stems. Anxiety levels among aides were determined by scores on the T-Anxiety scale (Form

Y-2) of the State-Trait Anxiety Inventory (STAI, Form Y). A short questionnaire was used to obtain demographic information and nursing home work history.

Data were analyzed by a linear model of regression, with an $\alpha = .05$ level of significance. A Tukey test was conducted for post hoc pairwise comparisons. Pearson product moment correlation coefficients, t -tests for comparing sample means, measures of central tendency, and percentages were also used to analyze data.

Conclusions

From the results of this study the following conclusions were drawn:

1. According to the manual (Rotter & Rafferty, 1950), persons scoring 135 or above on the RISB, with 75% to 85% accuracy, may be considered to be maladjusted. Twenty percent of the nursing aides scored 135 or above; 31% of the college freshmen on whom the RISB was normed scored within that range. However, the mean personality adjustment score for the nursing aide sample was not significantly different from the mean score for the group of college freshmen.

2. The mean T-Anxiety score for nursing aides was 5.72 points higher than the norm for working adults (Spielberger, 1983)--a statistically significant difference.

3. A positive correlation was found between personality adjustment scores and anxiety scores among aides. Aides who expressed strong conflict in their

interpersonal relationships tended to have higher anxiety scores.

4. Personality adjustment scores for aides were not significantly related to age, length of time employed in nursing homes, or the number of nursing homes in which aides had worked.

5. When personality adjustment scores for aides were examined in relation to nursing home, shift, age, liking of job, and gender, the overall relationship was not significant. The only significant variable in the model was whether aides liked or disliked the job. Aides who indicated they did not like the job scored significantly higher on the RISB than did aides who stated they liked the job.

6. Anxiety scores for aides were not significantly related to age, length of nursing home employment, or the number of nursing homes in which aides had worked.

7. When anxiety scores of aides were regressed on nursing home, shift, age, liking of job, and gender, the overall squared multiple correlation was significant. Significant variables in the model were nursing home, shift, and age.

A significant difference in anxiety scores was found between mean scores of the aides in only two of the five nursing homes in the study. Nonsignificant differences were found among all other possible pairings of mean scores of

aides in the five nursing homes. Aides on the evening work shift (3 p.m. to 11 p.m.) had a significantly higher level of anxiety than did aides on the morning shift (7 a.m. to 3 p.m.) or the night shift (11 p.m. to 7 a.m.). Younger aides tended to have higher anxiety scores than did older aides, but this effect emerged only after variance due to nursing home and shift were controlled through regression analyses.

Implications of the Findings

Although a lower percentage of nursing aides in the study had RISB scores high enough to be considered maladjusted than did the norm group of college freshmen, it should be noted that one of every five aides made responses to sentence stems which indicated strong conflict in interpersonal relationships. When coupled with the finding that anxiety scores among aides were significantly higher than the norm for working adults, it is evident that the role of nursing aides in nursing homes and those who fill that role are important issues in health care. Both a tendency toward conflict in interpersonal relationships and/or a high level of anxiety for a nursing aide can present serious limitations to providing kind, empathic patient care and can contribute to elevated tension among staff. Specific implications of the findings are as follow:

1. Because the personality adjustment of the nursing aide is vitally important to the quality of patient care, aide applicants should be psychologically screened in order

to eliminate, insofar as possible, persons who have a tendency toward conflict in interpersonal relationships and/or high anxiety-proneness. Either or both of these traits may predispose an aide to be physically or verbally abusive to patients.

2. Areas within the organizational framework of the nursing home identified by nursing aides as being anxiety-inducing need to be examined by nursing home management to find ways to reduce the anxiety or to compensate for it. Among these areas are the perceptions on the part of aides of inadequate pay, lack of recognition, excessive physical demands of the job, working short of help, a feeling of inadequacy about job performance, and aide concerns regarding patient abuse.

3. Counseling should be made available to staff, and particularly to nursing aides, to assist them in coping with the unavoidable anxieties attendant to working in a nursing home. Among these anxieties are the death of patients, the vicarious experience of one's own aging, and the emotional fatigue of caring for physically, mentally, and emotionally frail patients, many of whom have little hope for improvement.

4. The findings of this study indicate a need for human relations specialists to be employed in nursing homes to implement personality testing, to teach techniques for adaptive coping with anxiety, to develop programs which

provide emotional support for staff, to teach facilitative communication skills for improving interpersonal relationships, and to provide individual counseling for staff when needed.

5. Researchers and observers have placed much emphasis on the responsibility of nursing home management and staff to meet the psychosocial needs of patients. The present findings indicate that the psychosocial needs of patients cannot be met adequately without the realization by management that it also has a responsibility to respond to the work-related psychosocial needs of nursing aides. To this researcher, the psychosocial needs of aides and patients are so interrelated that they are inseparable.

Recommendations for Further Research

Based on the results of this study, the following recommendations are made for further research:

1. Research is needed to develop a culture-free psychological screening instrument specifically for use with persons seeking employment as nursing aides in nursing homes. Such an instrument should include a measure of an applicant's tendency toward personality adjustment/maladjustment and anxiety-proneness. An assessment should be made of an applicant's attitudes toward caring for sick and dying persons as well as the ability to work with roving, combative, confused, withdrawn, or depressed patients in a kind and gentle manner. Any discernible need

on the applicant's part to fulfill an authoritarian role should be examined.

2. Research is needed to determine more definitively factors which contribute to high anxiety levels among nursing home nursing aides and also those factors which could tend to make one work shift more anxiety-inducing than another.

3. Additional research is needed to determine to what extent anxiety among aides in a particular nursing home may be affected by internal processes, such as style of management, changes in administrative and/or supervisory personnel, investigations by regulatory agencies, or by negative news coverage of nursing homes.

4. In order to provide a basis for improving relationships and teamwork among nursing staff, additional research should focus on how RNs, LPNs, and nursing aides working in the same facility perceive their relationships and their recommendations for improving and strengthening those relationships.

5. The psychosocial needs of nursing home patients have been widely discussed in the literature. Little concern has been demonstrated for meeting the work-related psychosocial needs of nursing aides. Further research should focus on defining and understanding these needs.

6. The relationship of personality adjustment and anxiety in interpersonal relationships in stressful work

environments needs further study. The limited body of knowledge now available should be expanded in order to generate a theoretical basis for training and practice conducive to reducing anxiety levels in stressful occupations.

Final Observations Regarding the Findings

In their responses to the RISB, the majority of aides stated a sense of fulfillment about working with people, and particularly old people. In general they also stated strong ties to their own families. Although no stem words directly related to religion, one-third of the aides indicated a religious orientation in their lives.

In spite of their stated commitment to the type of work they do--or maybe because of it--more than half of the aides responded to the RISB sentence stem, My nerves with negative statements that showed varying degrees of anxiety; more than one-third reported frequent feelings of sadness, loneliness, and depression.

Not only do they experience the physical and emotional fatigue of caring for older patients, aides, in particular among staff, suffer from the "almshouse image" of nursing homes held by our society. Their lack of professional nursing credentials, a low work status in the nursing home, and the absence of a public forum for improving their vocational image make them particularly vulnerable to

negative attitudes which may be held by professional nursing staff, patients, families, and the general public.

Of great importance to patients and their families, and ultimately to the public image of nursing homes, is the selection of aides with well-adjusted personalities who have a sense of fulfillment in caring for older persons with multiple physical problems, probable mental impairment, and fragile emotional stamina. Coupled with the selection and training of compassionate and competent aides is the retention of these aides. For patients, the familiar face and voice of a caring aide who understands their physical and emotional capabilities and limitations is comforting and reassuring. As a step toward retaining dedicated nursing aides and reducing the high cost of turnover, it seems important that nursing home management conscientiously study and eliminate, insofar as possible, work-related anxieties attendant to the role of nursing aide.

In summary, the nursing home is an environment which taxes the job skills, emotional capacity, physical stamina, and human relations skills of nursing aides each and every day. If more than routine physical care is to be given, the aide must have an intuitive understanding that a balm for the human spirit is as necessary to patients in a nursing home as is the effort to alleviate their physical suffering. Without a sense of mission toward accomplishing both of those goals, the aide is working in a "hopeless" medical

environment in which the prognosis for most patients is continued physical deterioration, accompanied by declining mental faculties and increased feelings of despair.

For nursing aides, the nursing home is a day-to-day reminder of the physical and mental decrements of aging and ultimate death to which aides are also heir. Any tendency of the aide to personal maladjustment and anxiety-proneness can be exacerbated by working in a nursing home environment to the detriment of patients, families, and other staff members, and to the diminution of the therapeutic climate of the nursing home. Even moderate levels of anxiety and personality maladjustment may have a synergistic effect which taxes the mental and emotional stamina of a nursing aide beyond endurance and the aide may become abusive to patients, absent from work psychologically or physically, or may select the option of quitting the job.

For aides themselves, for patients who live in nursing homes in ever-increasing numbers, for families who feel they have no alternative for the care of a family member, and for society as a whole, the amelioration of the problems related to the selection, training, and the retention of qualified and compassionate nursing aides has a note of urgency.

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APPENDIX
QUESTIONNAIRE

1. How long have you, worked in this nursing home?
Years _____ Months _____ Weeks _____
2. How long have you worked in other nursing homes?
Years _____ Months _____ Weeks _____
3. In how many other nursing homes have you worked?

(Please circle answers to questions 4, 5, and 6)

4. Do you like your job? Yes No
5. Do you like older people? Yes No
6. Female Male
7. Age _____

BIOGRAPHICAL SKETCH

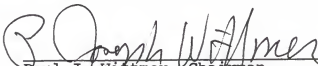
Eleanor Cunningham was born in Georgia in 1927. She received a Bachelor of Arts degree from LaGrange College, a Master of Arts from Sam Houston State Teachers College, and a Specialist in Education degree from the University of Florida.

Through her mother's profession as a social worker, Eleanor became aware at an early age of the physical and emotional needs of other persons. Following her M.A. degree with major emphasis on criminology and counseling, she worked as a counselor in a women's prison. From this experience, she became particularly interested in both those who work and those who live in what Goffman (1961) termed "total institutions," such as prisons and nursing homes. In such institutions those who live in the institution generally have their physical and social activities supervised by a staff who do not live in the facility but who determine the rules and regulations for persons who do reside there.

As her parents grew older, Eleanor became concerned about persons who give and those who receive institutional health care. This concern prompted her return to school to

specialize in gerontological counseling and has led to both a counseling practice and volunteer work with older persons and with staff in nursing homes.

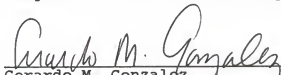
I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.


Paul J. Wittmer, Chairman
Professor of Counselor Education

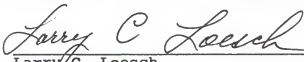
I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.


Linda M. Crocker
Professor of Foundations of
Education

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.


Gerardo M. Gonzalez
Associate Professor of Counselor
Education

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.


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This dissertation was submitted to the Graduate Faculty of the College of Education and to the Graduate School and was accepted as partial fulfillment of the requirements for the degree of Doctor of Philosophy.

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